

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08982

1. PLACE OF DEATH a. COUNTY <u>P.A. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Openfield - Md</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel General</u>				d. STREET ADDRESS <u>8704 Tioga Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u>		First Middle Last <u>ABERG</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-65</u>	9. AGE (In years lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>19</u> Min. <u>67</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Alexandria, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT L. ABERG</u>			14. MOTHER'S MAIDEN NAME <u>ANNE H. HELTZEL</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT (MOTHER) Address <u>ANNE H. ABERG 8704 TIOPA RD. OPENFIELD, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury Skull.</u> DUE TO (b) <u>Auto accident - Tractor trailer</u> DUE TO (c) <u>Crushing Injury Skull.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>auto accident - Tractor trailer</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:15</u> a.m. <u>1967</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>APCO MD</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		EXAMINER'S NAME (Type) <u>F. L. INHART</u>		22. DATE SIGNED <u>7-18-67</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ht. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>J. Wm. Lee & Sons</u>		ADDRESS <u>4th + Macdonald</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

5292

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08984

08983

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>75-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Media</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DANNE ARONDEL - General.</u>				d. STREET ADDRESS <u>N. Providence Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>J.</u> Last <u>AMMON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-64</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Sharon Hill, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Robert D. Ammon</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ammon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Richard Ammon (Uncle)</u>			Address <u>Cape St. Clair Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury Skull</u> <u>816.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>25 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7-3</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>ANCO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>7-3-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>JULY 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD MEM. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BROOMALL PA.</u>	
24. FUNERAL DIRECTOR <u>Beall Funeral Home</u>				25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08984

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>PA</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A - Anne Arundel General</i>		e. STREET ADDRESS <i>14 Providence Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>D</i> Last <i>AMMON</i>		4. DATE OF DEATH Month <i>7</i> Day <i>3</i> Year <i>19 67</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-32</i>
9. AGE (In years lost birthday) yrs. <i>35</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tel. Co.</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Cable Splicer</i>	
13. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. FATHER'S NAME <i>Arthur Ammon</i>		16. MOTHER'S MAIDEN NAME <i>Adelaide Ammon</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT <i>Richard Ammon (Brother) Maryland</i>		Address <i>Cape St. Clair</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Fracture Skull</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Subdural</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>7/3</i> 19 <i>67</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>AA CO MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhart</i>		22. DATE SIGNED <i>7-3-67</i>	
EXAMINER'S NAME (Type) <i>E. Linhart</i>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>JULY 7, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD MEM. CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>BROOMALL PA</i>	
24. FUNERAL DIRECTOR <i>Beall Funeral Home</i>		ADDRESS <i>1212 West St. Anna.</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1878

FOR STATE HEALTH DEPT.

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08986

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08985

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital			d. STREET ADDRESS 1348 Chester Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle — Last ATKINSON			4. DATE OF DEATH Month July Day 6 Year 1967		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-35	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salv		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D C	
13. FATHER'S NAME Rosevelt Atkinson			14. MOTHER'S MAIDEN NAME Martha Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Martha Smith Address —	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's cirrhosis with marked fatty metamorphosis 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.			22. DATE SIGNED July 7, 1967		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE THEREOF 7-15-67	23c. NAME OF CEMETERY OR CREMATORY Int'l Calvary Cmt	23d. LOCATION (City or Town) (County) (State) A.A. Co Md	25a. REC'D BY REGISTRAR DATE JUL 12 1967	
24. FUNERAL DIRECTOR Shay O'Leary 1000 Brantley Rd.			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 9 Taney Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine G. ATWELL		4. DATE OF DEATH Month Day Year July 2 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-1900
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME ANGELO J. GERACI		14. MOTHER'S MAIDEN NAME MARY COBURN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT TILDEN O. ATWELL		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Art. C.V. Disease & Hypertension DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , to 7/2/67 that (I) (we) last saw the deceased alive on 7/2/67 , and that death occurred at 12:50 A.M. from causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) M. F. KLAUANS, M.D.		22d. ADDRESS 31 SOUTH GATE AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-4-67	23c. NAME OF CEMETERY OR CREMATORY St. Annes	23d. LOCATION (City or Town) (County) (State) Annapolis A.D. MD.
24. FUNERAL DIRECTOR John M. Long		25a. REC'D BY REGISTRAR JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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OFFICE OF DEATH

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d Film #G391 8/11/67 ph

08988

CERTIFICATE OF DEATH

08987

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30.4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 21223</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>207 Amity St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Barnes</u>				4. DATE OF DEATH Month Day Year <u>7 31 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W/C-20</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>-/-/81</u>	
9. AGE (In years lost birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
13. FATHER'S NAME <u>Edmond Gittins</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT Address <u>Hospital Records, Crownsville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>9/19</u> , 19 <u>62</u> , to <u>7/31</u> , 19 <u>67</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>7/31</u> , 19 <u>67</u> , and that death occurred at <u>6:30M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>	
24. FUNERAL DIRECTOR <u>MORTON E Dyett F.H.</u>				ADDRESS <u>1701 LAURENS ST.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

651

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08988

1. PLACE OF DEATH a. COUNTY <u>H.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR Nursing HOME</u>		d. STREET ADDRESS <u>504 STATE ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Mary</u> Last <u>Barry</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. CLDR DR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1877</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>FAIRMOUNT, MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>LEONARD BUARK</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH McGRATH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>WALTER BARRY</u> Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> , to <u>25 July</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>16 APR. 1</u> 19 <u>67</u> , and that death occurred at <u>8A</u> , M, from causes and on the date stated above.	
22a. SIGNATURE <u>Edward S. Dean</u>		22b. DATE SIGNED <u>7-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Franklin St. Annapolis, MD.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Lyons Annapolis, Md</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

000000

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[Illegible Signature]

cc - [Illegible]
[Illegible Signature]
[Illegible Date]

[Illegible text at bottom of page]

CERTIFICATE OF DEATH

08990

08989

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 924 Wells Ave.,	
3. NAME OF DECEASED (Type or print) First Leonard Middle Joseph Last BARRY		4. DATE OF DEATH Month July Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1896
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY Ret	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH BARRY		14. MOTHER'S MAIDEN NAME GERTRUDE RUARK	
15. WAS DECEASED OVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214050639A	
17. INFORMANT FELICIA H. BARRY #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal and Bleeding DUE TO 5400 (b) (?) peptic ulcer DUE TO 17 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic CVD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 7-10-67 to July 11, 1967 , that (I) (we) last saw the deceased alive on July 11, 1967 , and that death occurred at 5:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 7-13-67	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-14-67	
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR John M. Loggins & Sons		25a. REC'D BY REGISTRAR DATE JUL 17 1967	
25b. REGISTRAR'S SIGNATURE John M. Loggins & Sons		25c. REGISTRAR'S SIGNATURE John M. Loggins & Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

453

CERTIFICATE OF DEATH

08930

08991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapter 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fernside - Glen Burnie</u>		c. LENGTH OF STAY IN lb <u>Fernside - Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convalescent Ctr.</u>		d. STREET ADDRESS <u>17 Rosedale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	9. AGE (In years last birthday) yrs. <u>79</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA #2</u>	
13. FATHER'S NAME <u>Henry Street KFus</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Fehr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-20-6259</u>	
17. INFORMANT <u>Richard N. Bartel</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHF</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/5/67</u> , 19 <u>67</u> , to <u>7/25/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/23/67</u> , 19 <u>67</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. B. Ramirez</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. B. RAMIREZ</u>		22d. ADDRESS <u>3927 ANNA POOL RD BOLL 27</u> <u>1622 NORTHBORNE RD BOLL 12</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>7/28/67</u>	<u>Loudon Park Cem.</u>	<u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>A. F. Ware</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			

00001

STATEMENT OF DEBIT

10000

No —
Henry Street
Telephone Co.
Barbara Felt
Richard M. Bartel
same
42 42

11-1-11

212-107

July 21 1911

London Fair Co. Baltimore, Md.

CERTIFICATE OF DEATH

08991

08992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS Crownsville, Maryland	
3. NAME OF DECEASED (Type or print) Liston E. Batson		4. DATE OF DEATH Month 7/ Day 19 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/06
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		10b. KIND OF BUSINESS OR INDUSTRY Seaman	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Batson		14. MOTHER'S MAIDEN NAME Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service) Yes USCG		16. SOCIAL SECURITY NO. 156-03-5558	
17. INFORMANT G Hospital Records, Crownsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 4221 IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture Right leg (Operated-open reduction) Chronic Brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 67 to 7/19 , 19 67 , that (I) (we) last saw the deceased alive on 7/19 , 19 67 , and that death occurred at 2:00 M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 7/19/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Singleton		25a. ADDRESS Singleton Funeral Home	
		25b. CITY Glen Burnie, Maryland	

3222

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08992

08993

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>RIVA ROAD R.F.D #3</u>	
3. NAME OF DECEASED (Type or print) <u>THEODORE F. BAUSUM</u>		4. DATE OF DEATH <u>JULY 28 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1920</u> yrs. <u>47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXCAVATING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN E. BAUSUM</u>		14. MOTHER'S MAIDEN NAME <u>MARY FARRELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WWII - KOREA</u>		16. SOCIAL SECURITY NO. <u>WV 11 - KOREA</u>	
17. INFORMANT <u>Dorothy S. BAUSUM</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>8244</u> IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.) <u>Crash between body & frame of dump truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9/28</u> 19 <u>67</u> p.m. <u>6</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>ANNAPOLIS MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>7/28/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D.	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-31-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Long</u>		ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 2 1967</u>			

Mr. W. H. Hester
7-31-07
Hillcrest
Annapolis, Md.

Annapolis, Md.

Charles
Hester

X

X

X

Dorothy S. Bausum

Mary Farrell

Excavating Construction A.A. Co. Md.

8-15-1920 W7

Bausum

X

Theodore

White

Yes Will-Korea

John E. Bausum

Riva Road RFD #3

D.O.A.

Kearl Annapolis

Annapolis

Marland Annapolis

CERTIFICATE OF DEATH

08994

08993

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 411 Old Stage Rd.	
3. NAME OF DECEASED (Type or print) Daniel First Middle Last		4. DATE OF DEATH Month 7 Day 4 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-01
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Purch. Agent		10b. KIND OF BUSINESS OR INDUSTRY Md. Cup Co.	
11. BIRTHPLACE (County & State, or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Beckman		14. MOTHER'S MAIDEN NAME Katherine Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1919-1923		16. SOCIAL SECURITY NO. 218-12-4352	
17. INFORMANT Mrs. Martha Beckman (wife)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Coronary art. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE H. G. Summers		22b. DATE SIGNED 7.4.67	
22c. PHYSICIAN'S NAME (Type) H. G. Summers MD		22d. ADDRESS 1101 Patuxent Ave Balto	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08995

08994

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah Grace BENNING</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/92</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ashland, Mass.</u>		
13. FATHER'S NAME <u>John Andrew Wagner</u>			14. MOTHER'S MAIDEN NAME <u>Ida May Libby</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Harry Benning Falesville Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach c metastases</u> DUE TO (b) <u>to lung and thoracic spine</u> DUE TO (c) <u>151X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Falesville AA MD</u>	21. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1967</u> , to <u>June 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/28/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>			22d. ADDRESS <u>Shady Side, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laker</u>	23d. LOCATION (City or Town) (County) (State) <u>Falesville AA MD</u>				
24. FUNERAL DIRECTOR <u>Bernard Hardisty Falesville Md</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

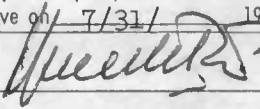
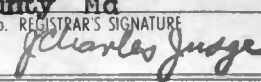
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d File #0391 8/11/67 ph
CERTIFICATE OF DEATH

08996

03995

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21201			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1058 Argyle Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Duane B. Best				4. DATE OF DEATH Month 7 Day 31 Year 1967			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/38	
9. AGE (In years last birthday) 29 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Best				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-8447		17. INFORMANT Address Hospital Records, Crownsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493 X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 6/26 , 1967, to 7/31 , 1967, that (H) (we) last saw the deceased alive on 7/31 , 1967, and that death occurred at 12:00M , from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/31/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22d. ADDRESS Crownsville, State Hospital, Maryland			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 8/5/67		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetry		23d. LOCATION (City or Town) (County) (State) A A County Md	
24. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave.				25a. REC'D BY REGISTRAR DATE AUG 2 1967		25b. REGISTRAR'S SIGNATURE 	

1933

STATE OF TEXAS

IN SENATE,
January 10, 1933.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

ENDING DECEMBER

31, 1932.

ALBUQUERQUE, N. M.

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PRINTED BY

THE NEW MEXICO

PRINTING CO.

ALBUQUERQUE, N. M.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08997

CERTIFICATE OF DEATH

08996

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albert Augustus BIRCKHEAD		4. DATE OF DEATH Month Day Year July 18 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1892
9. AGE (In years last birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Farmer	
11. BIRTHPLACE (County & State, or foreign country) Paris Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Albert E. Birkhead		14. MOTHER'S MAIDEN NAME Helen Prouett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-8729	
17. INFORMANT Mrs. Birkhead - Gambrills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO ant. C. V. R. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ant. C. V. R. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs. Yes.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Swallow previous C.V.A		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) husband attended the deceased from 7/18 , 19 67 , to July 18, 1967 , that (I) XX last saw the deceased alive on July 18, 1967 , and that death occurred at M. from causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans		22b. DATE SIGNED 9:45 PM	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, MD		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF 7/21/67	
23c. NAME OF CEMETERY OR CREMATORY Middleham Cem.		23d. LOCATION (City or Town) (County) (State) Lusby Calvert Md	
24. FUNERAL DIRECTOR Hopping Funeral Home Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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John Smith

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08997

08998

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY AA.CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS HARNESS CREEK	
3. NAME OF DECEASED (Type or print) First James. Middle J. Last Blackwell		4. DATE OF DEATH Month 7 Day 14 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1907
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY RET.	
11. BIRTHPLACE (State or foreign country) HARTSVILLE, S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES A. BLACKWELL		14. MOTHER'S MAIDEN NAME TINY CHASE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. WV 11	
17. INFORMANT ELIZABETH V. BLACKWELL		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850X DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interval between onset and death DUE TO 1 hour (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boating Accident - Chesapeake Bay	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7/13 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, place bldg., etc.) Chesapeake Bay		20f. (City or town) (County) (State) AA.CO. MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E.L. Vharst		22. DATE SIGNED 7-14-67	
EXAMINER'S NAME (Type) E.L. Vharst		M.D. Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-18-67	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or town) (County) (State) ANNAPOLIS AA. MD.	
24. FUNERAL DIRECTOR John M. Taylor & Son Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JUL 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

08999

08999

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 403 Irene Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 403 Irene Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leona Middle Boggs Last 4. DATE OF DEATH Month July Day 22 Year 1967				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 30, 1875 9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Franklin Furnace, Ohio 12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Andrew T. Bryan 14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Lorraine Evens Address 403 Irene Drive Glen Burnie				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 334X DUE TO Advanced age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 57 to 7/22 , 19 67 , that (I) (we) last saw the deceased alive on 7/11 , 19 67 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph Taler M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/24/67				22c. PHYSICIAN'S NAME (Type) JOSEPH TALER 22d. ADDRESS 95 Bynoch Rd. Glen Burnie Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 7/24/67 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery 23d. LOCATION (City, town or county) (State) Ashland, Kentucky				24. FUNERAL DIRECTOR McCully Funeral Home ADDRESS 237 Patapsco Ave. Baltimore, Md. 25a. REC'D BY REGISTRAR JUL 25 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie, Md</i> c. LENGTH OF STAY IN 1b <i>304</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Flora Major Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen, Baltimore, Md</i> d. STREET ADDRESS <i>3316 W. Franklin Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DAVID</i>		4. DATE OF DEATH Month <i>July</i> Day <i>14</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-8-1986</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Hanger</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md</i>
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>214-10-0050</i>	
17. INFORMANT <i>Joseph Simms</i>		Address <i>P.O. Box 53 Cheltenham</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>pulmonary congestion</i> (a), stating the underlying cause last. DUE TO (c) <i>Residual pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 day</i> <i>several weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8-21</i> , 19 <i>62</i> to <i>7-14</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>7-14</i> , 19 <i>67</i> , and that death occurred at <i>10:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard H. Hunt</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>		22d. ADDRESS <i>100 Cherry Lane, Glen Burnie, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7-19-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Nelson Funeral Home-1348 Calhoun Street</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 17 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Hanover d. STREET ADDRESS Hillcrest Rd., Timberridge e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle M. Last Bosien		4. DATE OF DEATH Month 7 Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-99
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Dorsey Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ambrosius		14. MOTHER'S MAIDEN NAME Margaret Reimsnyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XXXXXX no		16. SOCIAL SECURITY NO. 213 48 9818	
17. INFORMANT Elsworth Bosien (son)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2000 DUE TO Carcinomatosis General (b) Reticulo-cell Sarcoma DUE TO Reticulo-cell Sarcoma (c) Reticulo-cell Sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1966 , to 7/12, 1967 , that (I) (we) last saw the deceased alive on Jan 11, 1967 , and that death occurred at 5:55 AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph Taler		22b. DATE SIGNED 7/12/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER		22d. ADDRESS 95 ARVANART Rd. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 15/67	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Howard Co., Maryland
24. FUNERAL DIRECTOR Singleton		25a. REC'D BY REGISTRAR JUL 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09002 CERTIFICATE OF DEATH 09001									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 5 Box 207					d. STREET ADDRESS Rt. 5, Box 207				
3. NAME OF DECEASED (Type or print) Margaret C. Botzler					4. DATE OF DEATH Month 7 Day 13 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-1894		9. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) DANVILLE Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HARVEY M. SEIDEL					14. MOTHER'S MAIDEN NAME UNK.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 915 03 5138		17. INFORMANT MRS. GEORGE K. KUEHNE #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO (b) acc. D.D.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senil. DUE TO (c) Senil.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1955 , 19 to 1967 , 19, that (I) (we) last saw the deceased alive on 7-7-67 , 19, and that death occurred at 84 M, from the causes and on the date stated above.									
22a. SIGNATURE Robert R. Hahn					22b. DATE SIGNED 7-13-67				
22c. PHYSICIAN'S NAME (Type) Robert R. Hahn, M. D.					22d. ADDRESS P.O. Box 73, Severna Park, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 7-16-67		23c. NAME OF CEMETERY OR CREMATORY ASBURY		23d. LOCATION (City, town or county) (State) ARNOLD MD.		
24. FUNERAL DIRECTOR John M. Lykens Annapolis, Md.					25a. REC'D BY REGISTRAR JUL 17 1967				
					25b. REGISTRAR'S SIGNATURE [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09003

CERTIFICATE OF DEATH

09002

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>15</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery County</u> d. STREET ADDRESS <u>15</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara Bowen</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1898</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. <u>10</u> <u>15</u>		4. DATE OF DEATH <u>7</u> <u>10</u> <u>1967</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> 11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u> 12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>		13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Hospital Records, Crownsville Maryland</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>63</u> , to <u>7/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>67</u> , and that death occurred at <u>12:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M. D.</u> 22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22b. DATE SIGNED <u>7/10/67</u> 22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>7/21/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u> 23d. LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>		24. FUNERAL DIRECTOR <u>William Reese, Jr. - Crownsville Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 24 1967</u>			

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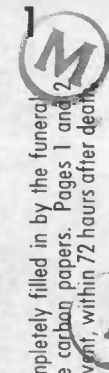
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09004

CERTIFICATE OF DEATH

09003

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PAROLE</u>		c. LENGTH OF STAY IN 1b <u>PAROLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RIVA ROAD</u>		d. STREET ADDRESS <u>RIVA ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH DEBB BOWEN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1881</u>
9. AGE (In years last birthday) yrs. <u>86</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CAVERT Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>REVERDY BOWEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE M. RAWHINGS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ELIZA H. BOWEN #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X INANITION</u> DUE TO (b) <u>CARCINOMA OF PROSTATE</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>SEVERAL YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PNEUMONIA RIGHT LOWER LOBE, ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>29 JUL 1967</u> that (I) (we) last saw the deceased alive on <u>29 JUL 1967</u> and that death occurred at <u>830 P</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Kinzer</u> M.D.		22b. DATE SIGNED <u>31 JUL 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. KINZER, M.D.</u>		22d. ADDRESS <u>16 MURRAY AVE ANNAPOLIS, MD 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>		23d. LOCATION (City or Town) (County) (State) <u>BARSTOW MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Layton & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

2004

CERTIFICATE OF DEATH

DECEASED
NAME
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

INMATE
CANCER OF PROSTATE
PREVIOUS TREATMENT

DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

09005

CERTIFICATE OF DEATH

09004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Rural	
c. LENGTH OF STAY IN 1b /////		d. STREET ADDRESS 120 Baltimore Ave. S.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amelia		4. DATE OF DEATH Month 7 Day 4 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-06
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Holzner		14. MOTHER'S MAIDEN NAME Catherine E. Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen M. Baisley (daughter)		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Cerebral Vascular Hemorrhage 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Several Prior accidents as before DUE TO (c) - CIRRHOSIS OF LIVER - ALCOHOLIC -			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Carlos E. Arrabal</i>		22b. DATE SIGNED 7-4-67	
22c. PHYSICIAN'S NAME (Type) CARLOS E ARRABAL		22d. ADDRESS 2705 MOUNTAIN RD - 21122 -	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR <i>Eugene B. Starnes</i> Singleton Funeral Home		25a. REC'D BY REGISTRAR JUL 6 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

1910

WASHINGTON, D. C.

Division of Entomology
20-21 Bureau Building
Washington, D. C.

Report of the
Entomologist
for the year 1910

Published by the
Government Printing Office
Washington, D. C.

Price 10 cents
Per copy
Sold by the
Government Printing Office

For sale by the
Government Printing Office
Washington, D. C.

1910

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09006 CERTIFICATE OF DEATH 09005									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL, Davidsonville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>Fran-Mar Farm</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy Virginia BROWN</u>		First Middle Last		4. DATE OF DEATH <u>July 22 1967</u>		Month Day Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3 1928</u>		9. AGE (in years last birthday) <u>39</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Afton, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>JOSHUA FRANKLIN KINZER</u>				14. MOTHER'S MAIDEN NAME <u>LUTIE MARGARET (KINZER) WILGUS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>(Husband) John M. Brown, same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asthma, acute, allergen unknown</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma, perennial, multiple allergens</u> DUE TO (c) <u>-----</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>15 years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary emphysema</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 30</u> , 19 <u>67</u> , to <u>July 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> 19 <u>67</u> , and that death occurred at <u>2:08 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles W. Kinzer</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 22, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>					22d. ADDRESS <u>16 Murray Avenue, Annapolis, Md. 21401</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS Md.</u>			
24. FUNERAL DIRECTOR <u>Robert J. Beall</u>					25a. REC'D BY REGISTRAR <u>Charles J. [unclear]</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>		
BEALL FUNERAL HOME					ADDRESS <u>ANNAPOLIS MD 112 WEST ST.</u>		DATE <u>JUL 26 1967</u>		

03000

MAK

JUL 28 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Filed 7/19/67

09007

09006

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. LENGTH OF STAY IN TB <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u> <u>12.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Broadwater Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Buissett</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/09</u>	9. AGE (In years last birthday) <u>57 1/2</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Equipment operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HA Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hart, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Buissett</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>223 03 337</u>		17. INFORMANT <u>ESSIE D Buissett Churchton Md</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 61</u> , 19 <u>61</u> , to <u>July 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 1</u> , 19 <u>67</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Willard F. Smith</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>				22d. ADDRESS <u>Shady Side, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Green Haven HA MD</u>	
24. FUNERAL DIRECTOR <u>Bernard Harduty Salisbury Md</u>				25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u> </u>	

29033

CERTIFICATE OF DEATH

020047

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical history.]

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09008

CERTIFICATE OF DEATH

09007

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN lb 3 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		d. STREET ADDRESS 1930 Brady Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Burns		4. DATE OF DEATH Month July Day 17 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1891
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Warehouse	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 219 02 3434	
17. INFORMANT Lennox Ingram		Address 2415 Zion Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) Carcinoma of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1810		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/26 , 19 65 , to July , 19 76 , that (I) (we) last saw the deceased alive on 7/10 , 19 67 , and that death occurred at 11:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 17 July 1967	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22d. ADDRESS Hahn Professional Building, Severna Pk.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/67	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland Md	
24. FUNERAL DIRECTOR Andrew Inc. 1328 Sulphur Sp. Rd		25a. REC'D BY REGISTRAR DATE 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

80000

RECEIPT OF CASH

DATE PAID

10/11/1907

PAID TO ORDER OF

FOR

10/11/1907

George

Union

2.50

10/11/1907

10/11/1907

10/11/1907

10/11/1907

10/11/1907

10/11/1907

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10/11/1907

10/11/1907

09009

CERTIFICATE OF DEATH

09008

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN lb 56 yrs. + d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reese Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Reese Road (Rt. #2) e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EVA M. BUSSEY		4. DATE OF DEATH Month Day Year JULY 5 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Lerch		14. MOTHER'S MAIDEN NAME Helen Barjak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Minnie Escavage (daughter)		Address 7001 Athol Ave. Balto. 27	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis, Generalized DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 yrs Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan 1967 , to July 5, 1967 that (1) (we) last saw the deceased alive on July 1 1967 , and that death occurred at 9:15 M. from causes and on the date stated above.			
22a. SIGNATURE Edward G. Skerritt		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward G. Skerritt, M.D.		22d. ADDRESS Gambrills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR R. V. Singleton		25a. REC'D BY REGISTRAR JUL 7 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

00003

LOCATION OF DEATH

John at home Mar. 1941

REMARKS: + 30000

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09009

09010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AN. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Burnie</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena.</u> 02-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A-NORTH PRUNOEL-Hosp. 5469-Kenton-Rd</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janice D Cain</u>				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-48</u>		9. AGE (In years last birthday) yrs. <u>18</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melvin Cain</u>				14. MOTHER'S MAIDEN NAME <u>June Birrane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>8194</u> IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto struck fixed object</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>7:29</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>ANCO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		EXAMINER'S NAME (Type) <u>F. Linhardt</u>		M.D.		22. DATE SIGNED <u>7-29-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto Natl Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Co MD</u>	
24. FUNERAL DIRECTOR <u>McCully F H 237 Patapsco Ave 21225</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09011

CERTIFICATE OF DEATH

09010

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 90 Charles St.		d. STREET ADDRESS 90 Charles St.	
3. NAME OF DECEASED (Type or print) Nannie C. Callahan		4. DATE OF DEATH Month 7 Day 10 Year 67	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/93
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 7 Days 10	11. IF UNDER 24 HRS. Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Galax, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Choate		14. MOTHER'S MAIDEN NAME Ellen Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214 441879	
17. INFORMANT Thomas L. Callahan		Address 90 Charles St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/11/67 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on____, 19____, and that death occurred at____ M, from causes on and on the date stated above.			
22a. SIGNATURE Stephen B. Hiltabidle		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.		22d. ADDRESS 121 Cathedral St. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-15-1967	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City or Town) (County) (State) Bluewell Md Va
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR James J. Jones	
25b. REGISTRAR'S SIGNATURE James J. Jones		DATE JUL 12 1967	

MEDICAL CERTIFICATION

08011

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09011

FOR STATE
HEALTH DEPT

09012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catoonsville - 03-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Harsh around Camp. 330 Stratford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward W. Chaffman</u>		4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-08</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>1</u> Min. <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Representative Union Tel. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Walter E Chaffman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Poulson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215 03 7478</u>	
17. INFORMANT <u>Mary E. Chaffman</u>		Address <u>330 Stratford Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral disease</u> DUE TO <u>4344</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>7-9-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. <u>Assistant Medical Examiner</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>7-12-67</u>	<u>Woodlawn Cem</u>	<u>Woodlawn Bello Co Md</u>
24. FUNERAL DIRECTOR <u>Burgee Funeral Home 3631 Falls Rd Bello</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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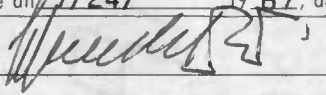
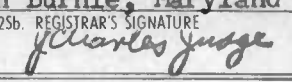
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09012

09013

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month 7 Day 24 Year 1967		5. SEX M	
6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/19	
9. AGE (In years lost birthday) yrs. 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Micheal Chick		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Air Force 1942-1945		16. SOCIAL SECURITY NO. 218-07-4205		17. INFORMANT Hospital Records Crownsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and organizing massive myocardial infarction on the heart. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Thrombosis of arteriosclerotic coronary vessels. DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease; chronic Brain Syndrome					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/5/ , 19 66 , to 7/24/ , 19 67 , that (1) (we) last saw the deceased alive on 7/24/ , 19 67 , and that death occurred at 7:20M , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 7/24/67		22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.	
23a. BURIAL (Cremation, Removal (Specify) Burial)		23b. DATE THEREOF July 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland		24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy, Balto, Md			
25a. REC'D BY REGISTRAR JUL 28 1967		25b. REGISTRAR'S SIGNATURE 			

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville (P.O.)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 441 Poplar Road		d. STREET ADDRESS 441 Poplar Road	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle CIRRI Last CIRRI		4. DATE OF DEATH Month July Day 31 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Feb. 1910
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Mechanic	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Cirri		14. MOTHER'S MAIDEN NAME Marie Corsello	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-4622	
17. INFORMANT Mrs/ Laura Cirri - Wife (same as # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of bone DUE TO (b) Care no medical DUE TO (c) lost		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 6 , 19 66 , to July 31 , 19 67 , that (I) (we) last saw the deceased alive on July 31 , 19 67 , and that death occurred at 1:50 PM , from causes on and on the date stated above.			
22a. SIGNATURE Robert Walsing		22b. DATE SIGNED 7/31/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3 Aug 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR AUG 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4130C

09014

09015

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b ANNAPOLIS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNAPOLIS NURSING HOME				d. STREET ADDRESS 117 LAFAYETTE AVE			
3. NAME OF DECEASED (Type or print) Lee F. Clemens				4. DATE OF DEATH Month JULY Day 29 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1894	
9. AGE (In years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CARRIER RET. U.S. GOV'T		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		11. BIRTHPLACE (County & State or foreign country) Milton, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME ANDREW CLEMENS			
14. MOTHER'S MAIDEN NAME BETTIE NORICK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WWII			
16. SOCIAL SECURITY NO.				17. INFORMANT CATHERINE B. CLEMENS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to 7/29 , 19 67 that (I) (we) last saw the deceased alive on 7/10 , 19 67 , and that death occurred at 12:50 A.M. from causes and on the date stated above.							
22a. SIGNATURE Maurice F. Klawans M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/29/67	
22c. PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS				22d. ADDRESS 31 SOUTHGATE AVE			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-1-67		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BAHOTO MD.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE AUG 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00015

AND ARABER

ANABOLIS

ANABOLIS MARINE HOTEL

MALE WHITE

MAIL CARRIER RT 2. COMPT

ANDREW CLEMENS

YES WWI

CONCERN OF PROSTITUTE

CATHERINE B. CLEMENS #2

BETTIE HORICONK

WILTON, Pa.

3-11-1894 23

July 29

117 LATAYETTE AVE

ANABOLIS

MARYLAND

AND ARABER

8-1-17

NEW CATHEDRAL

BALTO

MARVICE F. KILMAN 31 SOUTHGATE AVE

1003

1/2

1/2

MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b 09 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL, ANNAPOLIS, MD.				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 1 SOUTHGATE AVENUE							
3. NAME OF DECEASED (Type or print) SCHAMYL (NMN) COCHRAN		4. DATE OF DEATH Month JULY Day 1 Year 19 67		5. SEX MALE							
6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 MARCH 1986							
9. AGE (In years last birthday) 81 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMMANDER		10b. KIND OF BUSINESS OR INDUSTRY USN RETIRED	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
11. BIRTHPLACE (County & State, or foreign country) HOUSTON, TEXAS		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME JEROME BOWLING COCHRAN							
14. MOTHER'S MAIDEN NAME ANNE WALKER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1904-1946		16. SOCIAL SECURITY NO. 559-14-4459							
17. INFORMANT INA HUBARD, BOX 52 CAVES RD., OWINGSMILLS, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER TUMOR 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) BRONCHO PNEUMONIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 22 JUNE , 1967 , to 1 JULY , 19 67 , that (I) (we) last saw the deceased alive on 1 JULY , 1967 , and that death occurred at 6:10A from the causes and on the date stated above.											
22a. SIGNATURE <i>L. W. Johnson</i>		22b. DATE SIGNED 1 July 67		22c. PHYSICIAN'S NAME (Type) LT L. W. JOHNSON, MC USNR							
22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL									
23b. DATE THEREOF 7-5-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.							
24. FUNERAL DIRECTOR <i>John M. Taylor & Sons</i>		25a. REC'D BY REGISTRAR JUL 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

MEDICAL CERTIFICATION

33018

AMINO ACID

ANALYSIS

69 DAYS

ANALYSIS

NAVAL HOSPITAL, ANNAPOLIS, MD.

1 BOUTWELL, FRED

SCHMIDT

(BORN)

MOORE

JULY

67

NAME

X

25 MARCH 1965

COAST GUARD

USE REQUIRED

WATER, TANK

LEWIS BOWLING CO.

AMERICAN

1904-1916

1921-1922

1923-1924

1 JULY

67

1965

JULY

67

AT I. . . JOHNSON, MC USNR

NAVAL HOSPITAL, ANNAPOLIS, MD.

09017

CERTIFICATE OF DEATH

09016

1. PLACE OF DEATH a. COUNTY <u>ANNA ARUNDEL Co. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hosp.</u>		d. STREET ADDRESS <u>125 Cherrie Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence W. Cole</u>		4. DATE OF DEATH <u>July 6, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balta. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Ridgway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Betty Cole</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Chronic Generalized Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-</u> , 19 <u>67</u> , to <u>July 6</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>July 1</u> , 19 <u>67</u> , and that death occurred at <u>7:44 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Hunt</u>		22b. DATE SIGNED <u>7-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>		22d. ADDRESS <u>100 Cherry Lane, Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, Md.</u>
24. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		25. REC'D BY REGISTRAR <u>JUL 12 1967</u>	
ADDRESS <u>1000 Brantley Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09018

CERTIFICATE OF DEATH

09017

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA-RURAL d. STREET ADDRESS 506 SYLVIE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARTHA First Middle Last C. COLE		4. DATE OF DEATH Month Day Year JULY 4 1967						
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 3, 1893	9. AGE (In years last birthday) yrs. 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (Ret.)	11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Coatsworth		14. MOTHER'S MAIDEN NAME Lena Mae Bender		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 162-14-5597-0		17. INFORMANT Mrs William Cole (Daughter in Law) #2 Address Same as
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) acute Myocardial Infarction DUE TO (b) Anteroseptal Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 7 days years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-26 - 1967 , to 7-4, 1967 , that (I) (we) last saw the deceased alive on 7/4 1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above.								
22a. SIGNATURE Mary T. O'Herlihy		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-4-67		
22c. PHYSICIAN'S NAME (Type) Mary T. O'Herlihy M.D.		22d. ADDRESS #5 Central Ave. S/W Glen Burnie, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION (City or Town) (County) (State) California, Penna.		
24. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE Frank J. Judge		

61030

OPTIONAL FORM NO. 10

U.S. GOVERNMENT PRINTING OFFICE: 1962 O - 350-100

Blackburn (Rev.) Dan Jones

James Blackburn

62-14-2507-3 Mrs. William Jones (Daughter of Dan) 25

cont. handwritten letter
William Jones

copy given

W. J. Jones
W. J. Jones

25

62-14-2507-3

California, Fresno

July 1, 1962

William Jones

San Francisco, Cal.

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

54

3

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09019

09018

1. PLACE OF DEATH e. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, d. STREET ADDRESS 7869 Crain Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine E. Connery First Middle Last		4. DATE OF DEATH 7 11 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William D. Beynon		14. MOTHER'S MAIDEN NAME Welch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Catherine Connery Box 235 Severn, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. S. C. V. D. 7221 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cardiac failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-25 , 1967 , to 7-11 , 1967 , that (I) (we) last saw the deceased alive on 7-11 , 1967 , and that death occurred at 5 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert Dabolins M.D.		22b. DATE SIGNED 7-13-67	
22c. PHYSICIAN'S NAME (Type) Robert Dabolins		22d. ADDRESS 400 Crain Hgwy. N. W. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/14/1967	23c. NAME OF CEMETERY OR CREMATORY St. Vincent's	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink		25a. REC'D BY REGISTRAR JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

08019

Anna Arnold

John Arnold

North Arnold

Catherine

White

Thomas

William

John

Welch

Caroline

Robert

1714-1907

Raymond C. Pink

JUL 11 1957

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09019

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital D.O.A.		d. STREET ADDRESS 626 Binstead Road	
3. NAME OF DECEASED (Type or print) FRANK FRAZIER COON III		4. DATE OF DEATH Month July Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1934
9. AGE (In years lost birthday) yrs. 33		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.C.G.		10b. KIND OF BUSINESS OR INDUSTRY U.S.NAVY.	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK F. COON JR.		14. MOTHER'S MAIDEN NAME FLORENCE J. LITTLEFIELD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES 1952-1967		16. SOCIAL SECURITY NO. 214-30-6924	
17. INFORMANT MRS. HARRIET L. COON		Address 626 Binstead Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 816.4 IMMEDIATE CAUSE (a) Multiple fractures including: ribs DUE TO mandible and left femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subject driver in auto-auto collision			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject driver in auto-auto collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:26 7 16 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Dorsey Rd. 1000 ft. w Wirth Rd.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED July 17, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county) 322 S. HIGH ST. BALTO. Md.	
23a. BURIAL CREMATION, EMBALM (Specify) EMBALM		23b. DATE THEREOF JULY 20 /67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM. ARLINGTON VA.		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR Frank Dilly Noe		25a. REC'D BY REGISTRAR JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

02030



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

09020

09021

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West-River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - ANNE HUNDEL-GEN.</u>		d. STREET ADDRESS <u>1032 S. Edison St..</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Lee</u> Last <u>Copenhaver</u>		4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-20</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wade Copenhaver</u>	
14. MOTHER'S MAIDEN NAME <u>Stella Lineweaver</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>Yes N/A</u>		17. INFORMANT <u>Ethel Copenhaver (wife)</u> Address <u>same as #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8508</u> DUE TO <u>Strangely</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Strangely</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>See overhead X-ray to start material</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7-15</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chiropractic Day</u>		20f. (City or town) (County) (State) <u>ARLINGTON MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. W. H. H. H.</u> M.D.		22. DATE SIGNED <u>7-17-67</u>	
EXAMINER'S NAME (Type) <u>E. L. W. H. H. H.</u>		22. DATE SIGNED <u>7-17-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedarwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Edinburg, Shenandoah Va.</u>	
24. FUNERAL DIRECTOR <u>Hopping Funeral Home - Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>		25c. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>	

13020



15. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09022

CERTIFICATE OF DEATH

09021

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- GLEN BURNIE c. LENGTH OF STAY IN 1b 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-PASADENA d. STREET ADDRESS LAKE SHORE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THERESA M. COUNCILL		4. DATE OF DEATH Month Day Year JULY 31 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893 JANUARY 3, 1894
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Anton Smith		14. MOTHER'S MAIDEN NAME Mary Kannengeiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Thomas C. Chase, Jr., 505 W. University		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure DUE TO (b) Cerebrovascular accident DUE TO (c) Essential Hypertension CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH hours day years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23 1967 to July 31 1967 , that (I) (we) last saw the deceased alive on July 31 1967 , and that death occurred at 9:24 AM , from causes and on the date stated above.			
22a. SIGNATURE Max C Frank		22b. DATE SIGNED 7/31/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SE Ritchie Hwy Glen Burnie MD 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/67	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR AUG 1 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

09023

Item #9 Film #G391 7/21/67 ph

CERTIFICATE OF DEATH

09022

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 105 Maryland (Severn)		c. LENGTH OF STAY IN lb 4 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 105 Maryland Ave.		d. STREET ADDRESS 105 Maryland Ave.	
3. NAME OF DECEASED (Type or print) First IRA Middle K. Last CROW		4. DATE OF DEATH Month July Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Dec. 1881
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 07 Days 05 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banking (ret)		10b. KIND OF BUSINESS OR INDUSTRY Point Marion Bk.	
11. BIRTHPLACE (County & State, or foreign country) Fayette Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Crow		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 81-16-0805	
17. INFORMANT Mr. Ernest O. Knapp- 5, Maryland Ave.		Address Severn, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO Coronary Vase Disease (c) Coronary Vase Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 7/21, 19 67 , to 7/25/67 , that (I) (we) last saw the deceased alive on 7/21/67 , and that death occurred at 3:30 a.m. from causes and on the date stated above.			
22a. SIGNATURE Robert P. Ware		22b. DATE SIGNED 7/25/67	
22c. PHYSICIAN'S NAME (Type) ROBERT P. WARE, M.D.		22d. ADDRESS BALTIMORE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/67	
23c. NAME OF CEMETERY OR CREMATORY EverGreen Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Point Marion, Fayette, Pa.	
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Maryland		25a. REC'D BY REGISTRAR Robert P. Ware	
25b. REGISTRAR'S SIGNATURE Charles J. Jones		DATE JUL 26 1967	

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153-1-1082

707

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09024

09023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 024			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 730 Glenwood Street			
3. NAME OF DECEASED (Type or print) First Robert Middle Monroe Last CRUTCHLEY				4. DATE OF DEATH Month July Day 1 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1888	
9. AGE (In years lost birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME THOMAS F. CRUTCHLEY				14. MOTHER'S MAIDEN NAME ALICE CRUTCHLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-05-1162A		17. INFORMANT DOUGLAS N. CRUTCHLEY Address EDGEWATER Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Skeletal malformation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1961 , to 7/1, 1967 that (I) (we) last saw the deceased alive on 7/1, 1967 , and that death occurred at 5:20 P.M. from causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 7/3/67		22c. PHYSICIAN'S NAME (Type) DR. DOUGLAS N. CRUTCHLEY	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF JULY 5, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF Cem.	
24. FUNERAL DIRECTOR BEALL FUNERAL HOME				25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

00024

STATEMENT OF DEATH

NAME: [illegible]
AGE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

2:50 P.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09025

CERTIFICATE OF DEATH

09024

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 2 Box 51 COMPTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Crownsville, Maryland, 21032</u>	
3. NAME OF DECEASED (Type or print) <u>Clement L. Delahay</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/95</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u> Hours <u>19</u> Min. <u>67</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank Delahay</u>	
14. MOTHER'S MAIDEN NAME <u>IDA DRURY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-36-6673</u>		17. INFORMANT <u>Hospital Records Crownsville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO (b) <u>Secondary Chronic Brain Syndrome associated with generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/23/1967</u> , to <u>7/21/1967</u> , that (I) (we) last saw the deceased alive on <u>7/21/1967</u> , and that death occurred at <u>12:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict</u>		22b. DATE SIGNED <u>7/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville Maryland 21032</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCIS XAVIER</u>	23d. LOCATION (City or Town) (County) (State) <u>COMPTON ST. MARY'S, MD.</u>
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2502

[illegible]

12100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

09026

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09025

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ADCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>O.O.A. - Anne Arundel Hosp</u>		d. STREET ADDRESS <u>BL 11 - B4118E</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine Anna Ege</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1908</u>
9. AGE (In years last birthday) yrs. <u>59</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Huthman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ranges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-50-8549</u>	
17. INFORMANT <u>McJohn Ege</u>		Address <u>Box 118E Rt 11 Pasadena Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>asthma</u> DUE TO (b) <u>asthma</u> DUE TO (c) <u>asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Further</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>7-12-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Md 99c.</u>	
24. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		ADDRESS <u>237 Pasadena Ave</u>	
25a. REC'D BY REGISTRAR <u>JUL 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6812

CERTIFICATE OF DEATH

09027

09026

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. Crownsville, Maryland			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital			d. STREET ADDRESS P.O. Box 216 (3rd Blvd.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Harry F. Faeser			4. DATE OF DEATH Month July Day 21 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/98		9. AGE (In years last birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - owner		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George Franklin Feeser			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 216-18-5561		17. INFORMANT Anita Viola Feeser Address Saverna Park, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypostatic Pneumonia DUE TO (c) Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/21/67 , 19 67 , to 7/21 , 19 67 , that (I) (we) last saw the deceased alive on 7/21 , 19 67 , and that death occurred at 9:45pm from causes and on the date stated above.					
22a. SIGNATURE Ludwig Benedict M.D.		22b. DATE SIGNED 7/22/67		22c. PHYSICIAN'S NAME (Type) Ludwig Benedict M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-25-67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven	
24. FUNERAL DIRECTOR Robert L. Berman, Severna Park, Md.		25a. REC'D BY REGISTRAR JUL 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09028

CERTIFICATE OF DEATH

09027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Linthicum</u>		c. LENGTH OF STAY IN lb <u>35 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u># 505 Heath Avenue</u>		d. STREET ADDRESS <u>#505 Heath Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine Anna Gardner</u>		4. DATE OF DEATH <u>July 13, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Trimmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gunther</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Margaret Adams (daughter)</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Coronary Thrombosis</u> DUE TO <u>H.E.O.O.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>H.E.O.O.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18y</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 2, 1959</u> to <u>Jan 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1967</u> , and that death occurred at <u>M</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Paul Schinfeld</u>		22b. DATE SIGNED <u>7/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul Schinfeld</u>		22d. ADDRESS <u>1301 Annapolis Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		25a. REGD BY REGISTRAR <u>July 17, 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

2002

CERTIFICATE OF DEATH

2002

No. 202 North Avenue
 Baltimore, Maryland 21202
 Female White
 Married
 Date of Birth: Nov. 14, 1923
 Date of Death: July 13, 2002
 Cause of Death: N. Leukemia 32 yrs
 Place of Death: Home
 Burial: St. Ignace Cemetery
 City: Baltimore, Maryland
 State: Md.
 County: Baltimore
 Registrar: [Signature]
 Date: July 15, 2002

[Faint text and stamps at the bottom of the page, including a circular seal and additional administrative markings.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09029

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Haven</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Haven</u> 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North ARUNDEL.</u>		d. STREET ADDRESS <u>RLI - BX 302 AI.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>S</u> Last <u>GARPSTAS.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/55</u>
9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school boy</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph J. Garpstas</u>		14. MOTHER'S MAIDEN NAME <u>Alfreda M. Lehmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mr. J. Garpstas (same)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9294</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming Shore House - Stony Creek</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7-7</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) <u>Stony Creek</u>		20f. (City or town) (County) (State) <u>AA Co MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>7-7-67</u>	
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Ritchie Hgwy., A.A.Co., Md.</u>	
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hgwy., Baltimore</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10000

U.S. ...

Alfred ...

(...)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09029

CERTIFICATE OF DEATH

09028

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. MARGARETS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>		d. STREET ADDRESS <u>79 Conduit St.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY C. GAY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1889</u>
9. AGE (In years last birthday) yrs. <u>77</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SEDALIA, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN H. GAY</u>		14. MOTHER'S MAIDEN NAME <u>ELLA SPAUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>KINGSBERRY W. GAY</u>		Address <u>Bywater Rd. ANNAPOLIS, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular</u> (c) <u>diarrhea</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 dy.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-20-67</u> to <u>7-20-67</u> , that (I) (we) last saw the deceased alive on <u>7-20-67</u> , and that death occurred at <u>6</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Donald M. Murphy</u>		22b. DATE SIGNED <u>7-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F M SHIPLEY</u>		22d. ADDRESS <u>ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>7-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Loggins & Sons</u>		25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09039

1. PLACE OF DEATH a. COUNTY <u>AA-Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA-Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ken Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>O.O.A-NORTH-ARUNDEL</u>		d. STREET ADDRESS <u>301-HASKELL Road.</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID L. GILMOUR Jr.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/19</u>
9. AGE (In years last birthday) yrs. <u>48</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David L. Gilmour Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Mae Davis.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Betty J. Gilmour, 301 Haskell Rd. Arnold,</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4341</u> IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>7-17-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July, 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery.</u>	23d. LOCATION (City or Town) (County) (State) <u>Chestertown, Kent, Md.</u>
24. FUNERAL DIRECTOR <u>Edward Yellow</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>	
ADDRESS <u>Wilmington Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00001

1

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]

09032

CERTIFICATE OF DEATH

09031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>415 Crain Highway S. E.</u>				d. STREET ADDRESS <u>415 Crain Highway S. E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Giunta</u> Last <u>Giunta</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 Feb 1895</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self - Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alphonse Giunta</u>				14. MOTHER'S MAIDEN NAME <u>Rose Aversa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-0713</u>		17. INFORMANT Address <u>Mrs. Catherine P. Giunta, same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> <u>4201</u> DUE TO <u>Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Myocardial infarction</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u>2 July, 1967</u> , that (I) (we) last saw the deceased alive on <u>2 July, 1967</u> , and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Chang</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul Chang, M. D.</u>		22d. ADDRESS <u>Main Ave. S. E., Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5 July 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Maryland</u>				25a. REC'D BY-REGISTRAR DATE <u>JUL 7 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

18090

STATE OF TEXAS

18090



18090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09033

09032

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLA ND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c. LENGTH OF STAY IN 1b 9 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE		d. STREET ADDRESS 1845-C PATTON DRIVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUZANNE Middle ROCHELL Last GRABILL		4. DATE OF DEATH Month JULY Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1967
9. AGE (In years lost birthday) yrs. 9		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Grabill		14. MOTHER'S MAIDEN NAME Freda Sue Napier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give way or dates of service) No N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT (father) Gilbert Grabill, 1845-C Patton Drive Md.		Address Ft Geo G Meade	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, generalized DUE TO (b) Hemorrhagic Pneumonitis predominantly left DUE TO (c) 7630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 July , 19 67 , to 12 July , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 July , 19 67 , and that death occurred at 9 a. M, from causes and on the date stated above.			
22a. SIGNATURE Fred M. Nomura		22b. DATE SIGNED 12 July 1967	
22c. PHYSICIAN'S NAME (Type) FRED M. NOMURA, MAJ, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 67	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR James L. Wade, Samuel, Inc		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE James L. Wade		25c. REGISTRAR'S SIGNATURE James L. Wade	

7-271362

CERTIFICATE OF DEATH

66030

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

DATE OF DEATH

SEX

DATE OF DEATH

DATE OF BIRTH

SEX

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DATE OF DEATH

09033

09034

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Unknown b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 yrs. 2 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) #16353 Clarence Grant		4. DATE OF DEATH Month 7 Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -1-/25
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carnus S.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO (b) Marked Anemia and Electrolyte Imbalance DUE TO (c) 293X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiplegia; Mental Deficiency			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 4/29/ , 19 53 , to 7/2/ , 19 67 , that (I) (we) last saw the deceased alive on 7/2/ 19 67 , and that death occurred at 3:15 M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-7-67	23c. NAME OF CEMETERY OR CREMATORY Not Casket	23d. LOCATION (City or town) (County) (State) Brooklyn Md
24. FUNERAL DIRECTOR Elroy Wilson, 1000 Brantley Ave., Baltimore, Md		25a. REC'D BY REGISTRAR JUL 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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King 4-00000

Granville

Granville State Hospital

Miss

State

Unknown

Unknown

Unknown

Granville State Hospital

Marked anemia and leukocytosis

Hemiplegia; focal epilepsy

1911-12

L. Benedict, M.D.

Granville State Hospital, Dayton

09035

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN lb 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle ALVIN Last HALLOCK				4. DATE OF DEATH Month July Day 14 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1896		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea food		11. BIRTHPLACE (County & State, or foreign country) Shadyside Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Atwell Hallock				14. MOTHER'S MAIDEN NAME Sarah Virginia Prout			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214541673		17. INFORMANT LINA B. Niemiller, Annapolis Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-14-67 , 19 July 14 , 19 67 , that (I) (see) last saw the deceased alive on July 14 , 19 67 , and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE A. T. Allen				22b. DATE SIGNED 7-15-67		22c. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.	
22d. ADDRESS 62 Cathedral St., Annapolis, Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 16 1967		23c. NAME OF CEMETERY OR CREMATORY Ladlesville		23d. LOCATION (City or Town) (County) (State) Ladlesville AD Md	
24. FUNERAL DIRECTOR Bernard Hardesty Ladlesville Md				25a. REC'D BY REGISTRAR JUL 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

28033

CENTINQUE OF DEATH

James Armesel

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09036

CERTIFICATE OF DEATH

09035

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>	
c. LENGTH OF STAY IN 1b <u>1 yr. 6 mos.</u>		d. STREET ADDRESS <u>St. 4214 - 53d Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Annapolis Nursing Home, 900 Van Buren St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Millard F. Handy</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1897</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George K. Handy</u>		14. MOTHER'S MAIDEN NAME <u>Jenny Combs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-62-1614</u>	
17. INFORMANT <u>Mrs. G. Rose Motley - Dr.</u>		Address <u>1404-Highland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema from CVA</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11 January 1967</u> to <u>21 July 1967</u> , that (I) (we) last saw the deceased alive on <u>21 July 1967</u> , and that death occurred at <u>16:35</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Beck</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

88038

STATE OF TEXAS

COUNTY OF DALLAS

1903



09037

CERTIFICATE OF DEATH

09036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> d. STREET ADDRESS <u>350 Oakwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anne Marie Hefferman</u>		4. DATE OF DEATH Month Day Year <u>July 27 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-90</u>
9. AGE (In years last birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-7689</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Septicemia generalized</u> DUE TO (c) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>hours</u> <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 27, 1967</u> , to <u>July 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1967</u> , and that death occurred at <u>6:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Max C Frank</u>		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>		22d. ADDRESS <u>425 SE 11th St S. S. Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore MD</u>
24. FUNERAL DIRECTOR <u>John J. Cowan & Son Inc</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

5502

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09037

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 912 Windsor Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Frances Hendricks		4. DATE OF DEATH Month Day Year July 18 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Ford		14. MOTHER'S MAIDEN NAME Annie Bull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Hospital RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - Pulmonary Embolism - 8124 DUE TO (b) Coronary Artery Disease - Myocardial Infarction DUE TO (c) Brain		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7-10 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) (County) (State) Annapolis MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Elmer G. Linhardt		22. DATE SIGNED July 18, 1967	
EXAMINER'S NAME (Type) Elmer G. Linhardt		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem.		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

09039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessop</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDUEL - Hosp.</u>		d. STREET ADDRESS <u>RL 175 - Box 419 A -</u>	
3. NAME OF DECEASED (Type or print) <u>Lothe</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/07</u>
9. AGE (In years and birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Orange Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Deffmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elivabeth Peacher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-1298</u>	
17. INFORMANT <u>Mrs. Beatrice Redmiles, Laurel, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>H500</u> IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>7-1-67</u>	
EXAMINER'S NAME (Type) <u>F. L. INHART</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>	23b. DATE THEREOF <u>July 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery,</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co., Maryland</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
Address		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

6. The sixth part is a list of references.
7. The seventh part is a list of references.
8. The eighth part is a list of references.
9. The ninth part is a list of references.
10. The tenth part is a list of references.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09040

09039

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1207 Leonard Drive</u>				d. STREET ADDRESS <u>1207 Leonard Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First Middle Last <u>Hoff</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1967</u>	
9. AGE (In years lost birthday) yrs. <u>02-1</u>		IF UNDER 1 YEAR Months <u>02</u> Days <u>10</u> Hours <u>40</u> Min. <u>40</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Joseph Hoff</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Patricia Makerham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother</u> Address <u>1207 Leonard Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>Premature rupture of membrane</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>40 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> 19 <u>67</u> , to <u>7-10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-10</u> 19 <u>67</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Coral Gordon</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Coral Gordon M.D.</u>				22d. ADDRESS <u>611 Park Ave. Balt. Md 21201</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>7.10.67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Medical Examiner's office</u>		23d. LOCATION (City, town, or county) (State) <u>Balt. 700 Fleet St. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
						DATE <u>JUL 18 1967</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7-252009



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09041

09043

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 179 Green St.	
3. NAME OF DECEASED (Type or print) First John Middle Benjamin Last HOLLIDAY, Jr.		4. DATE OF DEATH Month July Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1900
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager THEATRE		10b. KIND OF BUSINESS OR INDUSTRY THEATRE	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN B. Holliday		14. MOTHER'S MAIDEN NAME SARAH KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 060989A	
17. INFORMANT ANNIE KRAZ		18. ADDRESS 3 MAJOR AVE. BALTO. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) discovered attended the deceased from 7/5 , 19 67 , to July 5 , 19 67 that (I) had last saw the deceased alive on July 5 , 19 67 , and that death occurred at 10:55 PM M, from causes and on the date stated above			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 7/6/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 16 Murray Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-8-67	23c. NAME OF CEMETERY OR CREMATORY ST. ANNES	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.H. MD.
24. FUNERAL DIRECTOR John M. G. L. & Sons		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1934

CERTIFICATE OF DEATH

Place of Birth

Place of Birth

Occupation

Occupation

Date of Death

Date of Death

Age

Sex

Marital Status

Marital Status

Marital Status

Marital Status

By

Date

By

Date

Date

Witness
Name
Address

Witness
Name
Address

Witness
Name
Address

Witness
Name
Address

Age

Sex

Date

By

Date

Place of Birth

Place of Birth

Witness
Name
Address

Witness
Name
Address

Witness
Name
Address

Witness
Name
Address

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09042

CERTIFICATE OF DEATH

09041

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-PASADENA</u>	
c. LENGTH OF STAY IN lb <u>27 DAYS</u>		d. STREET ADDRESS <u>RT 9 BOX 166 POWHATTEN BEACH</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROLAND</u> <u>Howard</u> <u>JAWORSKI</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>31</u> <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 28, 1896</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mech. (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balt. City</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ludwig Jaworski</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW 1</u>	
16. SOCIAL SECURITY NO. <u>214-48-1558</u>		17. INFORMANT <u>Mr. Paul Jaworski Glen Burnie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Extensive myocardial infarction</u> DUE TO (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Digestive, Adrenal insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7.4</u> , 19 <u>67</u> , to <u>7.30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7.30</u> 19 <u>67</u> , and that death occurred at <u>7.30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>July 31, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY SUMMERS</u>		22d. ADDRESS <u>1101 Patapsco Ave, Balto. 25 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U.S. National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>R.V. SINGLETON</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09043

09042

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>18</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North AKUNDIEL</u>		e. STREET ADDRESS <u>Rt 2 - Box 876</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>F.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-48</u> 18 <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aluminum Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>T. Claude Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy K. Witter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-46-4288</u>	
17. INFORMANT <u>T. Claude Johnson, same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Injury</u> DUE TO (b) <u>Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Skull</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto burned over</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:18</u> a.m. <u>7:18</u> p.m. 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>AACO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>7/18/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>22 July 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Maryland</u>
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

5292

254-255

09043

09044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AAEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AAEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Buprie</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - NORTH ARUNDIEL</u>		d. STREET ADDRESS <u>3021 - Lytton Road</u>	
3. NAME OF DECEASED (Type or print) First <u>LETITIA</u> Middle <u>9</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-55</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James A Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Elsie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr James A Johnson</u>		Address <u>3021 Lytton Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: <u>9298</u> IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) <u>Sub</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Sub</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sub</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shimmy gravel pit</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7-1</u> p.m. 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Belle Grove Road</u>		20f. (City or town) (County) (State) <u>AAEO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>7-1-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		Address (Street, city, town, or county) <u>Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>ADOLPHUS HALSTEAD</u>		25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
Address <u>1206 W North Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1000

James A. ...
...

James A. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09044

09045

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 75 Clay St.,	
3. NAME OF DECEASED (Type or print) First Middle Last Ronald Anthony JOHNSON		4. DATE OF DEATH Month Day Year July 15 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1967
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1 14 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ronald Anthony Johnson		14. MOTHER'S MAIDEN NAME Janice Patricia Church	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Hyaline membrane disease DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT, NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (Antonio M. Rivera) attended the deceased from July 13, 1967 to July 15, 1967 that I (xx) last saw the deceased alive on July 15, 1967 , and that death occurred at 9:05 AM M, from causes on and the date stated above.		22a. SIGNATURE Antonio M. Rivera, M.D.	
22b. DATE SIGNED 20 Jul 67		22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.D.	
22d. ADDRESS South RivMedCent., Edgewater, Md.		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) 7/24/67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY MORGUE		23d. LOCATION (City or Town) (County) (State) Foot of Fleet St	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2043

RECORDS OF DEATH

State of New York

County of Albany

City of Albany

Married

Single

Married

July 12, 1901

Albany General Hospital

Age

Sex

Color

Profession

Religion

Married

July 12, 1901

Male

Albany General Hospital

Female

Albany General Hospital

Albany General Hospital

Albany General Hospital

None

No

July 12, 1901

Albany General Hospital

July 12, 1901

Albany General Hospital

Albany General Hospital

Albany General Hospital

July 12, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09046

CERTIFICATE OF DEATH

09045

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ANNAPOLIS NURSING HOME</i>		d. STREET ADDRESS <i>422 STATE ST.</i>	
3. NAME OF DECEASED (Type or print) <i>Esther C Jones</i>		4. DATE OF DEATH Month <i>July</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 20, 1884</i>
9a. AGE (In years last birthday) <i>82</i> yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Crozier</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Kilbroughel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220-07-1783-D</i>	
17. INFORMANT <i>Roger C. Jones #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221 Atherosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>66</i> , to <i>July</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>July 23</i> , 19 <i>67</i> , and that death occurred at <i>3:45</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>7/28/67</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>7-31-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR BLUFF</i>		23d. LOCATION (City or town) (County) (State) <i>ANNAPOLIS MD.</i>	
24. FUNERAL DIRECTOR <i>John M. Layton Sons Annapolis, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 31 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Annapolis c. LENGTH OF STAY IN 1b (Rural) Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Annapolis d. STREET ADDRESS Box 174-Rt. 2 Tydings on the Bay e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CAROLYN Middle B. Last KNOEDLER			4. DATE OF DEATH Month July Day 4 Year 1967						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1881		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William A. Gentry					14. MOTHER'S MAIDEN NAME Jennie Campbell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-44-2145		17. INFORMANT Mr. Elmer L. Knoedler			Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized arteriosclerosis DUE TO (c) 1 year								INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/19 , 19 66 , to 7/3 , 19 67 , that (I) (we) last saw the deceased alive on 6/16 19 67 , and that death occurred at 6 PM , from the causes and on the date stated above.									
22a. SIGNATURE R.M. McLaughlin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 7/5/67	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin				22d. ADDRESS 3708 Mountain Rd. Passaic, N.J.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/67		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. Park		23d. LOCATION (City, town or county) (State) Ridgewood, New Jersey.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

3020

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09048

CERTIFICATE OF DEATH

09047

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 19 Revell Street	
3. NAME OF DECEASED (Type or print) Ella Caroline		4. DATE OF DEATH Month July Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1879
9. AGE (In years lost, birthday) 88 yrs.		IF UNDER 1 YEAR Months 10 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? Sweden	
13. FATHER'S NAME PETER OLOF		14. MOTHER'S MAIDEN NAME BRITTA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS MILDRED CROCKETT #2		Address 10435	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supp. Pleasure DUE TO Cardio-Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Disease DUE TO (c) 10 YRS		INTERVAL BETWEEN ONSET AND DEATH 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY , 19 64 , to 15 JULY , 19 67 , that (I) (we) last saw the deceased alive on 14 JULY , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 7/15/67	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin Street, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/18/1967	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		23d. LOCATION (City or town) (County) (State) BALTIMORE MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR, S.O.N. ANNAPOLIS MD		25a. REG. BY REGISTRAR JUL 18 1967	
25b. REGISTRAR'S SIGNATURE James Judge		DATE	

1968



Annals

11. 11. 1968

1968

January 1, 1968

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09048

09043

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. LENGTH OF STAY IN 1b <u>30-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL CONVELESCENT CENTER 313 Hospital Drive</u>				d. STREET ADDRESS <u>1324 HILLMAN</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN JOSEPH KURGAN</u>				4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-28-09</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE-M.D.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>FRANK KURGAN</u>				14. MOTHER'S MAIDEN NAME <u>MARYANNA KRAWCZYK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-03-6356</u>		17. INFORMANT <u>ANTHONY KURGAN 6305 FAIR OAKS AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Carcinomatosis</u> DUE TO <u>Carcinoma of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cachexia</u> DUE TO (c) <u>Cachexia</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1561</u> <u>years</u> <u>months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>67</u> , to <u>7/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>67</u> and that death occurred at <u>12:50 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Max C Frank MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>				22d. ADDRESS <u>25 SE Ritchie Hwy Glen Burnie</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MARYLAND</u>	
24. FUNERAL DIRECTOR <u>John M. Weber & Sons, Inc. 401 S Chester</u>				25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

2004

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09050

CERTIFICATE OF DEATH

09049

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c. LENGTH OF STAY IN Tb 8 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL			d. STREET ADDRESS 8100 OGRMAN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JESSIE Middle M. Last LACHER			4. DATE OF DEATH Month JULY Day 26 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 July 1922	9. AGE (In years last birthday) yrs. 44	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Alfred Strutts		
14. MOTHER'S MAIDEN NAME Ella Pope			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No N/A		
16. SOCIAL SECURITY NO. 412-20-7053			17. INFORMANT Joe A. Lacher, Same as item #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 8 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from July 26 o, 19 67 , to July 26 , 19 67 , that (we) last saw the deceased alive on July 26 , 19 67 , and that death occurred at 7 P.M. from causes and on the date stated above.					
22a. SIGNATURE George J. Ramirez			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 26, 1967
22c. PHYSICIAN'S NAME (Type) JORGE J. RAMIREZ, CPT, MC			22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 30, 67	23c. NAME OF CEMETERY OR CREMATORY Phillips Cemetery	23d. LOCATION (City or Town) (County) (State) Waynes County, Tenn		
24. FUNERAL DIRECTOR Harold A. Wade, Samuel H. H.			25a. REC'D BY REGISTRAR DATE AUG 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

STATEMENT OF DEATH

00000

DECEASED

NAME

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TIME

CAUSE

PLACE

DATE

TIME

PLACE

DATE

NAME

DATE OF DEATH

NAME

DATE OF DEATH

DECEASED

DATE OF DEATH

NAME

NAME

DATE OF DEATH

NAME

DATE OF DEATH

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DATE OF DEATH

NAME

NAME

DATE OF DEATH

NAME

NAME

NAME

[Handwritten signature and text at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09051

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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 1, Box 583	
3. NAME OF DECEASED (Type or print) John Maurice MAYHEW		4. DATE OF DEATH Month July Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. plumber		10b. KIND OF BUSINESS OR INDUSTRY US Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Augustus Mayhew		14. MOTHER'S MAIDEN NAME Margaret (last name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-16-5738	
17. INFORMANT Francis R. Mayhew		717 Soanne Drive Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Coronary Infarction DUE TO (b) Carcinoma of Lung DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma of Lung, Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/11 , 19 67 , to 7/16 , 19 67 ; that (I) (we) last saw the deceased alive on 7/16 , 19 67 , and that death occurred at 9:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 7/17/67	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, MD		22d. ADDRESS Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.	
24. FUNERAL DIRECTOR E. Hopping HOPPING FUNERAL HOME		25a. REC'D BY REGISTRAR JUL 20 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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Item 18 b Film CERTIFICATE OF DEATH

09051

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1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>AA.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GLEN BURNIE</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Avenue 1.</i>		d. STREET ADDRESS <i>Atchafalaya Highway</i>	
3. NAME OF DECEASED (Type or print) First <i>Ernest A.</i> Middle <i>McAllister</i> Last <i>McAllister</i>		4. DATE OF DEATH Month <i>7</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-4-99</i>
9. AGE (In years lost birth day) <i>68</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>	11. BIRTHPLACE (County & State, or foreign country) <i>PA.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Preston McAllister</i>	
14. MOTHER'S MAIDEN NAME <i>Julia Byrd Low</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Spine</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i> <i>2 years</i> <i>19/1991</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1965, to <i>July</i> , 1967, that (I) (we) last saw the deceased alive on <i>July 19</i> , 1967, and that death occurred at <i>5 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Robert I. Levy</i>		22b. DATE SIGNED <i>7/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert I. Levy M.D.</i>		22d. ADDRESS <i>114 Medical Arts Bldg</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>7-28-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Glen A.M.C.A.</i>	23d. LOCATION (City or town) (County) (State) <i>Baltimore</i>
24. FUNERAL DIRECTOR <i>McCully - 237 Tatapoeco Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 26 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John J. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS P.O. Box-397	
3. NAME OF DECEASED (Type or print) First Ruth Middle Cecelia Last McCRARY		4. DATE OF DEATH Month July Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1912
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Day		14. MOTHER'S MAIDEN NAME Elsie Enders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, not or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Arthur McCrary #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Cerebral Vascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the deceased) attended the deceased from May , 19 67 , to July 25 , 19 67 , that (I) had saw the deceased alive on July 25 , 19 67 , and that death occurred at 8:40 PM M, from causes and on the date stated above.			
22a. SIGNATURE Elmer G. Linhardt, M.D.		22b. DATE SIGNED 7-26-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 3 Chesapeake Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7-28-1967	Park Lawn	Montgomery Co. Md.
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. RECEIVED BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE J. J. Judge		DATE	

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COUNTY OF DALLAS

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
09054 Items 8, 9 Film G390 7/11/67 wk											
09053											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Crownsville c. LENGTH OF STAY in lb 00 Box 171 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 171						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville d. STREET ADDRESS Box 171 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROLAND W. McKNEW						4. DATE OF DEATH Month Day Year JULY 7 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1911		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days 6 mo	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY self-empl. constr.				11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles W. McKnew						14. MOTHER'S MAIDEN NAME Martha Murray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no						16. SOCIAL SECURITY NO. 218-14-3174		17. INFORMANT Mrs. Ruth V. McKnew - same as #2 above Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic bronchogenic carcinoma 1621 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from March 1967 , to July 7, 1967 , that (I) (we) last saw the deceased alive on June 30, 1967 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. 22a. SIGNATURE Barbara C. Palmer M.D. 22b. DATE SIGNED 7-8-67 22c. PHYSICIAN'S NAME (Type) HOPPING FUNERAL HOME - Annapolis, Maryland 22d. ADDRESS Ann Arbor, Michigan 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jul. 11, 1967 23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cem. 23d. LOCATION (City, town or county) (State) Millersville, A.A. Md. 24. FUNERAL DIRECTOR'S SIGNATURE Beverly E. Hopping 25a. REC'D BY REGISTRAR JUL 11 1967 25b. REGISTRAR'S SIGNATURE Charles Judge											

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[Faint, mostly illegible text and markings covering the main body of the document, possibly representing a ledger or record book.]

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09055

CERTIFICATE OF DEATH

09054

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. CITY OR TOWN <u>Baltimore</u> <u>14 3rd Ave. Landsdowne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel</u>		d. STREET ADDRESS <u>14 3rd Ave. Landsdowne Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>McLaughlin</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/12/06</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk B&O Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Edward M. Crocken</u>		14. MOTHER'S MAIDEN NAME <u>Anna Barland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Laverne Davis</u> <u>95 A Rayford Dr., Pasadena, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Acute hemorrhagic pancreatitis</u> DUE TO (c) <u>Acute cholecystitis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/16/67</u> , 19 <u> </u> , to <u>7/18/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J.B. Ramirez</u>		22b. DATE SIGNED <u>7/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.B. RAMIREZ MD</u>		22d. ADDRESS <u>3427 ANNAPOLIS RD Balt 27</u> <u>1672 NORTHBOURNE RD Balt 12</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>7/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Form with multiple sections and fields, including a header area with a date field (1964), a title field (STATE OF TEXAS), and a body area with various text fields and checkboxes. The form appears to be a legal document, possibly a deed or a contract, with a large section for a description of the property or subject matter. The text is mostly illegible due to the quality of the scan.



RECEIVED BY THE STATE OF TEXAS
JUL 10 1964
OFFICE OF THE ATTORNEY GENERAL
AUSTIN, TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>A-A</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>H-A-C</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>713 Avondale Circle</u>						d. STREET ADDRESS <u>713 Avondale Circle</u>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>M</u> Last <u>McMAHON</u>						4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-85</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Patrick J. Munton</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Fahy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>212074965D</u>					
17. INFORMANT <u>J. Munton Dougherty</u>						Address <u>Above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cv Bladder</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u> </u> , to <u>1967</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>July 20 1967</u> and that death occurred at <u>4p</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. Hahn</u>						22b. DATE SIGNED <u> </u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>						22d. ADDRESS <u>P.O. BOX 73 Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda Md</u>			
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE <u>ROBERT S. BARRANCO</u>						DATE <u>AUG 3 1967</u>					

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G390 7/20/67 pc
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 48 Cornhill St.	
3. NAME OF DECEASED (Type or print) Martha Bishop MORGAN		4. DATE OF DEATH Month July Day 13 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880 Dec. 9, 1890
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Bishop		14. MOTHER'S MAIDEN NAME Anna Chew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Norris H. Morgan-48 Cornhill St. Anna. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Renal ischemia DUE TO (c) A.C.U.D.			INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rt. Hyper nephroma & Nephrectomy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from July 7, 1967 , to July 13, 1967 , that (I) (was) saw the deceased alive on July 13, 1967 , and that death occurred at 7:05 AM M. from causes and on the date stated above.			
22a. SIGNATURE Faye W. Allen		22b. DATE SIGNED 7:05 AM	
22c. PHYSICIAN'S NAME (Type) Faye W. Allen, M.D.		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 17-67	23c. NAME OF CEMETERY OR CREMATORY St. Anne's	23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
20 M 1/66

09058

CERTIFICATE OF DEATH

09057

1. PLACE OF DEATH a. COUNTY X Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GlenBurnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GlenBurnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 911 Rose Anne Rd. XXXXXX Glen Burnie, Md.	
3. NAME OF DECEASED (Type or print) Henry First Mueller Last		4. DATE OF DEATH Month July Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-89
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 15 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, e.g., fireman) Restaurant Business		10b. KIND OF BUSINESS OR INDUSTRY Restaurant Business	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-30-3893	
17. INFORMANT Mr. Charles Mueller, 911 Rose Anne Rd.		Address GlenBurnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO (b) Carcinoma of Stomach DUE TO (c) Carcinoma of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 151X 151X 151X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 6/10 , 19 67 , to 7-2 , 19 67 , that (we) last saw the deceased alive on 7-2 , 19 67 , and that death occurred at 7:30 AM, from causes and on the date stated above			
22a. SIGNATURE Howard H. Hubbard M.D.		22b. DATE SIGNED 7-2-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-5-1967	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Howard County, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JUL 6 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

10053

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
09059									
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>			c. LENGTH OF STAY IN 1b <i>7 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie, Md. 02-1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none Locust Rd.</i>					d. STREET ADDRESS <i>Locust Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Timothy</i> Last <i>Neff, Jr.</i>					4. DATE OF DEATH Month <i>July</i> Day <i>8</i> Year <i>1967</i>				
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>February 8, 1909</i>		9. AGE (In years last birthday) <i>58</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Fire Department</i>		11. BIRTH PLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John T. Neff, Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Blanche Giles</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>215-01-7593</i>		17. INFORMANT <i>Mrs John Neff, RFD 1</i> Address <i>Glen Burnie, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple myeloma</i> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>								INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>September 5, 1961</i> to <i>July 8, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 7, 1967</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>R.M. McLaughlin</i>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/8/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 11, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Ritchie Hwy., A.A.Co., Md.</i>			
24. FUNERAL DIRECTOR <i>George J. Gonce-4001 Ritchie Hwy., Baltimore</i>					25a. REC'D BY REGISTRAR DATE <i>JUL 12 1967</i>				
					25b. REGISTRAR'S SIGNATURE <i>Charles J. Gonce</i>				

26020

simultaneous

* 68-2250.

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09060

CERTIFICATE OF DEATH

09059

1. PLACE OF DEATH a. COUNTY AnneArundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 700 Americana Drive, Apt. 16				d. STREET ADDRESS 700 Americana Drive Apt. 16		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marian Marian				4. DATE OF DEATH Month July Day 17 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1908.	
9. AGE (In years last birthday) yrs. 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Beckenheimer				14. MOTHER'S MAIDEN NAME Margaret ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-20-2457		17. INFORMANT Mr. Chris Oehm Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/29 , 19 67 , to 7/12 , 19 67 , that (I) (we) last saw the deceased alive on 7/11 , 19 67 , and that death occurred at 8:30 M, from causes and on the date stated above.							
22a. SIGNATURE Richard I. Hochman				22b. DATE SIGNED 7/17/67		22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.	
22d. ADDRESS 16 Murray Ave, Annapolis, Md.				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/67.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR JUL 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0600

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (PV)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09061

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>W. O. A. G. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cassandra W. Parker</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1965</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>67</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Gerald Parker</u>		16. MOTHER'S MAIDEN NAME <u>Carolyn Sembley</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT <u>Carolyn Sembley</u>		Address <u>181 West St.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interrelated trauma, SPII</u> <u>535X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Shaken</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.O.		22. DATE SIGNED <u>7-29-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>8-1-1967</u>	<u>Prime Lawn</u>	<u>Annapolis Md</u>
24. FUNERAL DIRECTOR <u>William Reese Church</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		OAT AUG 3 1967	

The following is a list of the
 names of the persons who
 have been appointed to the
 various positions in the
 office of the Secretary of the
 State of New York for the
 year 1903.

The following is a list of the
 names of the persons who
 have been appointed to the
 various positions in the
 office of the Secretary of the
 State of New York for the
 year 1903.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

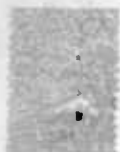
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09062

09062

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOR-NORTH. ARNDT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Parker</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 13-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	9. AGE (In years last birthday) <u>68</u> YRS.
11. BIRTHPLACE (State or foreign country) <u>Glen Burnie, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-26-7278</u>	
17. INFORMANT <u>Mrs. Mabel Parker (wife)</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		22. DATE SIGNED <u>7/18/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cem.</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1930



09063

CERTIFICATE OF DEATH

09063

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>147 PRINCE GEORGE ST.</u>		d. STREET ADDRESS <u>147 PRINCE GEORGE ST.</u>	
3. NAME OF DECEASED (Type or print) <u>EMIDIO</u> First Middle Last <u>PASQUALUCCI</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1875</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Co.</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY R.R. Co.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY R.R. Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>VINCENZO PASQUALUCCI</u>		14. MOTHER'S MAIDEN NAME <u>ANNA PONZIANI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>VINCEUZO PASQUALUCCI #2</u>	
17. INFORMANT <u>VINCEUZO PASQUALUCCI</u>		18. ADDRESS <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Failure</u> DUE TO <u>4331</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arrhythmia Fibrillation</u> DUE TO (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Not Known</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> , 19 <u>67</u> to <u>7-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> and that death occurred at <u>3:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>W.P. Stephens</u>		22b. DATE SIGNED <u>31 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.P. STEPHENS</u>		22d. ADDRESS <u>CORN HILL ST. ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Lyons</u>		25a. REC'D BY REGISTRAR <u>AUG 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Francis Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

33088

COPIES OF DEATH

Count of the
University of
Michigan

W. J. L. L.

7-28 34 7-30 12

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09064

CERTIFICATE OF DEATH

09064

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, Md.			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough AH				d. STREET ADDRESS 409 Ritchie Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sandra Renee Pezzotta				4. DATE OF DEATH Month July Day 24 Year 19 67				
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 23 Jul 67		
				9. AGE (In years last birthday) 1/365 yrs.		IF UNDER 1 YEAR Months 0 Days 1 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael D. Pezzotta				14. MOTHER'S MAIDEN NAME Dorothy J. Wynne				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT 409 Ritchie Highway Michael Pezzotta (f) Glen Burnie, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Incomplete expansion of liungs bilateral, DUE TO (c) marked							INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from 0800 23 Jul 19 67 , to 0115, 24 Jul 19 67 that (I) (we) saw the deceased alive on 0115, 24 Jul 19 67 , and that death occurred at 1:15 AM , from causes and on the date stated above.								
22a. SIGNATURE Capt Felix Almk				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/29/67		
22c. PHYSICIAN'S NAME (Type) GELIX CONTE, CPT, MC				22d. ADDRESS Kimbrough AH, Ft Geo G. Meade, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemeter		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md. A. A.		
24. FUNERAL DIRECTOR Raymond C. Fink				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JUL 26 1967		
						25b. REGISTRAR'S SIGNATURE Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09065

09065

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
c. LENGTH OF STAY IN lb 15 years		d. STREET ADDRESS 1661 Fort Davis Place, S. E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. C. Children's Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Pfarr		4. DATE OF DEATH Month July Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-37
9. AGE (In years lost birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 2 Days 9 Hours 5 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Pfarr		14. MOTHER'S MAIDEN NAME Catherine McHugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Children's Center Hospital, Laurel, Md.	
17. INFORMANT Children's Center Hospital, Laurel, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia - Hematemesis DUE TO aspirated (b) Possible peptic ulcer DUE TO 3255 (c) Mental retardation - severe		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 16 , 19 52 , to July 5 , 19 67 , that (I) (we) last saw the deceased alive on July 5 , 19 67 , and that death occurred at 7:50p M, from causes and on the date stated above.			
22a. SIGNATURE Margaret W. Mola		22b. DATE SIGNED 7-6-67	
22c. PHYSICIAN'S NAME (Type) MARGARET W. MOLA, M. D.		22d. ADDRESS Children's Center, Laurel, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-7-67	23c. NAME OF CEMETERY OR CREMATORY St. Johns	23d. LOCATION (City or Town) (County) (State) Johnstown Pa.
24. FUNERAL DIRECTOR Donald		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 17 1967	

208

STATE OF NEW YORK

1908

IN SENATE

12 MARCH

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

ON JANUARY 14, 1908

ALBANY:

WATKINS PUBLISHING CO.

1908

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09066

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b Baltimore (20)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Oss Pinter		4. DATE OF DEATH Month 7 Day 13 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/80
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 Year Months 13 Days 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephano Pinter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218 09 2771	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/23/ , 19 66 , to 7/13/ , 19 67 , that (I) (we) last saw the deceased alive on 7/13 , 19 67 , and that death occurred at 6.45 M, from causes and on the date stated above.			
22a. SIGNATURE C. Dorkan		22b. DATE SIGNED 7/13/67	
22c. PHYSICIAN'S NAME (Type) C. Dorkan, M.D.		22d. ADDRESS Crownsville, Maryland 21032	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/17/67	23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore City Md.
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 1407 Eastern Ave. #21	

2066

UNITED STATES OF AMERICA

Baltimore

Maryland

State of

Baltimore (20)

Crownsville

St. S. R. R.

Crownsville State Hospital

John

John

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Most Holy Redeemer

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CERTIFICATE OF DEATH

09067

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Collison Road	
3. NAME OF DECEASED (Type or print) Wilbur Wilbur Dewey PLATT		4. DATE OF DEATH Month July Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) officer, ret. Lt.		10b. KIND OF BUSINESS OR INDUSTRY US Navy	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John S. Platt		14. MOTHER'S MAIDEN NAME Prudence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) I & II		16. SOCIAL SECURITY NO. 212-34-5366T	
17. INFORMANT Emma E. Platt - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute an unrespected myocardial infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/26 , 19 67 , to 7/26 , 19 67 , that (I) (we) last saw the deceased alive on 7/26 , 19 67 , and that death occurred at 6:13 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE R. Brown		22b. DATE SIGNED 7/28	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jul. 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or Town) (County) (State) Ft. Meyer Va.
24. FUNERAL DIRECTOR Beverly L. Hopping Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR AUG 1 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09068

CERTIFICATE OF DEATH

09068

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JAMAICA-LONG ISLAND #11432 69-3	
c. LENGTH OF STAY IN 1b 9 DAYS		d. STREET ADDRESS 8907 169 ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 54 NORTH ARUNDEL GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle POLLOCK Last POLLOCK		4. DATE OF DEATH Month JULY Day 4 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 19, 1886
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel E. Distillator		14. MOTHER'S MAIDEN NAME Pauline Moritz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 085-05-5853	
17. INFORMANT Mrs. Marion Witte-		Address 1191 Hillcrest Rd., Odenton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO ASHD (b) Pulmonary Emphysema DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-25 , 19 67 to 7/4 , 19 67 that (I) (we) last saw the deceased alive on 7/4/67 , 19 67 , and that death occurred at 12:01 M, from causes and on the date stated above.			
22a. SIGNATURE James G. Hopping		22b. DATE SIGNED 7/4/67	
22c. PHYSICIAN'S NAME (Type) FELIX GRUBBERS		22d. ADDRESS 1113 Odenton Rd. Odenton Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Machteloh Cemetery	23d. LOCATION (City or Town) (County) (State) North Bergen Hudson N.J.
24. FUNERAL DIRECTOR Beverley E. Hopping Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 7 1967 DATE	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

09069

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 26.</i>		c. LENGTH OF STAY IN 1b <i>24 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none 910 Hilltop Road</i>		d. STREET ADDRESS <i>910 Hilltop Road</i>	
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Pope Sr.</i> Last		4. DATE OF DEATH <i>July</i> Month <i>5</i> Day <i>19</i> Year <i>67</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1895</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>19</i> Hours <i>5</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>St. Engineer - Ret'd - Baltimore City</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pittsburgh, Pa.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Pittsburgh, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Pope</i>		14. MOTHER'S MAIDEN NAME <i>Emma Schweinberg</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>24-01-2322</i>	
17. INFORMANT <i>Mr. William Pope</i>		Address <i>Baltimore 26.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerosis</i> (c) <i>Cancer of the lung</i> <i>diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>3 years</i> <i>6 months</i> <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1</i> , 19 <i>50</i> , to <i>July 5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>July 3</i> , 19 <i>67</i> , and that death occurred at <i>6 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R.M. McLaughlin</i>		22b. DATE SIGNED <i>7/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>		22d. ADDRESS <i>3708 Mountain Rd Pasadena, Md. 21222</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/7/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie A.A.Co.</i>
24. FUNERAL DIRECTOR <i>McCully Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Patapsco & 3rd St. 21225</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>JUL 6 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECORD OF DEATH

2000

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Place of Report	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT

MEDICAL-EXAMINER'S CERTIFICATE OF DEATH

09070

09070

1. PLACE OF DEATH a. COUNTY AA CO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis - MD. c. LENGTH OF STAY IN 1b Traceys Landing d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DON- Anne Arundel general		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY AA CO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Traceys Landing d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Angela Powell		4. DATE OF DEATH Month 7 Day 29 Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5-66
9. AGE (In years lost birthday) yrs. 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Powell		14. MOTHER'S MAIDEN NAME Margaret Chew	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Powell		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage (SDH) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 7/29/67		23. NAME OF CEMETERY OR CREMATORY Carters Ch. Cem	
24. FUNERAL DIRECTOR Lindsey E. Sewell		25a. REC'D BY REGISTRAR AUG 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS FriendShip AA. MD	

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Item 7 Film C390 7/20/67 kk

09071

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chesapeake</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>6 mths</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Letham MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First Middle Last				4. DATE OF DEATH <u>July 15 1967</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GROSS Samuel</u>				14. MOTHER'S MAIDEN NAME <u>Martha Gross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-54-9961</u>		17. INFORMANT <u>Rebecca Magee Letham MD</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - hypostatic.</u> DUE TO <u>Cerebral Thrombosis or Hemorrhage</u> (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease.</u> DUE TO (c) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> , 19 <u>67</u> , to <u>7/15</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>7/15</u> , 19 <u>67</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Lionel McHenry Mapp MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp MD</u>				22d. ADDRESS <u>Crownsville State Hospital, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-18-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mores</u>		23d. LOCATION (City or Town) (County) (State) <u>Wawey MD</u>	
24. FUNERAL DIRECTOR <u>William Reese #Cuma MD</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09072

CERTIFICATE OF DEATH

09072

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Crownsville State Hospital, Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Betty Elizabeth Rainey</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/01</u>
9. AGE (In years lost birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Rainey</u>		14. MOTHER'S MAIDEN NAME <u>Marita Luster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>due to CVA</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>p.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>65</u> , to <u>7/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/21</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>L. Mapp, M.D.</u>		22b. DATE SIGNED <u>7/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Mapp, M.D.</u>		22d. ADDRESS <u>Crownsville, Maryland 21032</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U. Maryland</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Reese, Jr. Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

37000

UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY OF DEFENSE

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09073

CERTIFICATE OF DEATH

09073

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G MEADE			c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS 7313 LAUREL-BOWIE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Infant Male				4. DATE OF DEATH Month JULY Day 26 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 JULY 1967		9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Rettke				14. MOTHER'S MAIDEN NAME Donna Snyder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Harry Rettke, Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APNEA DUE TO PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from 25 July , 19 67 , to 26 July , 19 67 , that (x) (we) last saw the deceased alive on 26 July 19 67 and that death occurred at 2:30 A.M. from causes on and on the date stated above.							
22a. SIGNATURE <i>Felix A. Conte</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 26 July 1967	
22c. PHYSICIAN'S NAME (Type) FELIX A. CONTE, CPT, MC				22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/27/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Calmar Manor Md.	
24. FUNERAL DIRECTOR <i>James A. ...</i>				ADDRESS <i>Laurel Md</i>		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>			

VR A15 (4)
25M 1/67

7-271494

67093

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.
1950

TO: THE ADJUTANT GENERAL
FROM: THE ADJUTANT GENERAL
SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report with various headings and paragraphs.]

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
09074					CERTIFICATE OF DEATH					09074				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>					d. STREET ADDRESS <u>Crownsville, Maryland 21032</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>George B. Rice</u>					4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>19 67</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/17/96</u>		9. AGE (In years lost birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Atlantic City, New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>William Rice</u>					14. MOTHER'S MAIDEN NAME <u>Ethel Woolburt</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>211-07-2898</u>		17. INFORMANT <u>Hospital Records, Crownsville Maryland</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ABS associated with alcoholic intoxication</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>67</u> , to <u>7/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes on and on the date stated above.														
22a. SIGNATURE <u>C. Dorkan, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/27/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>C. Dorkan, M.D.</u>					22d. ADDRESS <u>Crownsville, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U. Maryland</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>								
24. FUNERAL DIRECTOR <u>Wm. Reese, Jr. Annapolis, Md.</u>					25a. REC'D BY REGISTRAR <u>AUG 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

THE UNIVERSITY OF CHICAGO

OFFICE OF THE DEAN

00013

TO THE DEAN OF THE UNIVERSITY OF CHICAGO

FROM THE DEAN OF THE UNIVERSITY OF CHICAGO

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

RECEIVED
UNIVERSITY OF CHICAGO
OFFICE OF THE DEAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09075

CERTIFICATE OF DEATH

09075

1. PLACE OF DEATH o. COUNTY A A Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md b. COUNTY A H	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor		d. STREET ADDRESS 316 Milton Ave	
3. NAME OF DECEASED (Type or print) Lula First A Middle A Last Roberts		4. DATE OF DEATH Month July Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 25, 1866
9. AGE (In years last birthday) yrs. 100		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, had or had not, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Edgar Jennings		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 26, 1966 , to July 29, 1967 , that (I) (we) last saw the deceased alive on July 7, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE R M Smith		22b. DATE SIGNED July 29, 1967	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22d. ADDRESS Hahn Professional Bldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem		23d. LOCATION (City or Town) (County) (State) Balto Co Md	
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G391 7/26/67 kk

CERTIFICATE OF DEATH

09076

09076

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital			d. STREET ADDRESS 947 Coleridge Rd. 21229		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Myrtle Middle C. Last Robinson			4. DATE OF DEATH Month July Day 18 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1898	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John W. Wiegand			14. MOTHER'S MAIDEN NAME Kate Winn		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lynnwood M. Robinson, 947 Coleridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) 1 year					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 67 to 7/17 , 19 67 , that (I) (we) last saw the deceased alive on 7/17 , 19 67 , and that death occurred at 9:45 P M, from causes and on the date stated above.					
22a. SIGNATURE John P. Urlock Jr			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/19/67
22c. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr			22d. ADDRESS 1227 Washington Blvd. VE 7-0179		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			25a. REC'D BY REGISTRAR JUL 20 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09077

CERTIFICATE OF DEATH

09077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b ANNAPOLIS, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, ANNAPOLIS, MD.				d. STREET ADDRESS 37 NORTH GLEN AVE., ANNA., MD.			
3. NAME OF DECEASED (Type or print) First Middle Last ELIGIUS, Sr. LOUIS ROELLE, Sr.				4. DATE OF DEATH Month Day Year JULY 28 19 67			
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 December 1885		9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Musician		10b. KIND OF BUSINESS OR INDUSTRY US Navy Band		11. BIRTHPLACE (County & State, or foreign country) Jasper, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Roelle				14. MOTHER'S MAIDEN NAME Catherine Roelle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 215-48-5328		17. INFORMANT Address KATHRYNE R. KIRBY, 1608 VIRGINIA AVE., ANNA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 154X IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH METASTASIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7 July , 19 67 , to 28 July , 19 67 , that (I) (we) last saw the deceased alive on 28 July 19 67 , and that death occurred at 1543M , from causes and on the date stated above.							
22a. SIGNATURE James J. Quinn				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 28, 1967	
22c. PHYSICIAN'S NAME (Type) J. J. QUINN, LCDR MC USN				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Ft. Myer, Va.	
24. FUNERAL DIRECTOR BEALL FUNERAL HOME, ANNAPOLIS, MD.				25a. REC'D BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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RECORD OF DEATH

THE RECORD

RECORD

1911

1911

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

ELIUS, AR. 1911

ELIUS, AR. 1911

NAME

NAME

Chief Physician

Chief Physician

Chief Physician

Joseph H. H. H.

Joseph H. H. H.

1911

1911

RECORD OF DEATH

1911

1911

1911

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

NAVY HOSPITAL, ANNAPOLIS, MD.

09078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09078

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Rt. 5, Box 232C - Magothy Blvd.	
3. NAME OF DECEASED (Type or print) JAMES C. ROGERS		4. DATE OF DEATH Month July Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1914
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Langenfelder & Son	
11. BIRTHPLACE (State or foreign country) Wise Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raleigh Rogers		14. MOTHER'S MAIDEN NAME Lucy Dingus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 11 224 03 5690	
17. INFORMANT Mrs. Thelma Rogers (wife)		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (driver of car) car went on shoulder, collided with guard rail & turned over Subject Thrown from car	
20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 7/14 1967		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20e. (City or town) Baltimore		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 7/15/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Hamm Cemetery	23d. LOCATION (City or Town) (County) (State) Banner, Va.
24. FUNERAL DIRECTOR Singleton Funeral Home Glen Burnie, Maryland		25a. RECEIVED BY REGISTRAR JUL 17 1967 DATE	

BORN: July 18, 1887, New Cemetery
Washington, District of Columbia
Died: June 12, 1914, New Cemetery
Buried: June 12, 1914, New Cemetery

WIFE OF
JAMES H. HARRIS

WIFE OF
JAMES H. HARRIS

Lucy Harris

William Harris

224 G. Ave. N.E., Washington, D.C.

June 11

Truck Driver, Washington, D.C.

Jan. 12, 1914

X

CERTIFICATE OF DEATH

09073

09079

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home		d. STREET ADDRESS 209 North Hammonds Ferry Road	
3. NAME OF DECEASED (Type or print) Katherine Rose Rohner		4. DATE OF DEATH Month July Day 10 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH June 6, 1886
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Derrenberger		14. MOTHER'S MAIDEN NAME Annie Herbst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-54-9794	
17. INFORMANT Mr. Robert Wilson		Address 113 Cedarcroft Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 170X Carcinoma of breast with metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/12 , 1966, to 7/10 , 1967, that (I) (we) last saw the deceased alive on 7/5 , 1967, and that death occurred at 7/10 M, from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED 7/10/67	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22d. ADDRESS Hahn Professional Building, Severna Pk.,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/13/1967	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Wm. F. Tichner & Sons		25a. REC'D BY REGISTRAR DATE JUL 11 1967	
ADDRESS Baltimore, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2073

REPUBLIC OF CHINA

Name: [illegible]

Residence: [illegible]

Date of Birth: [illegible]

Place of Birth: [illegible]

Occupation: [illegible]

Sex: [illegible]

Marital Status: [illegible]

Education: [illegible]

Religion: [illegible]

Political Party: [illegible]

Signature: [illegible]

Date: [illegible]

Place: [illegible]

Signature: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09080

CERTIFICATE OF DEATH

09080

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Arnold	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS BOX 623 XXXXXXX XXXXX	
3. NAME OF DECEASED (Type or print) Genevieve T. ROSE		4. DATE OF DEATH Month July Day 27 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joshua Sank		14. MOTHER'S MAIDEN NAME Eliza Eliza - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. A. Rose, 7528 Carson Ave., 21224		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Coronary Artery Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-27-67 , to 7-27-67 , that (I) (we) last saw the deceased alive on 7-27-67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Frank Shipley		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type) FRANK SHIPLEY		22d. ADDRESS Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/31/67	
23c. NAME OF CEMETERY OR CREMATORY LOUBON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTO., MD.	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		24b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 4107 WILKENS AVE., 21229		25a. REC'D BY REGISTRAR DATE AUG 2 1967	

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09081

CERTIFICATE OF DEATH

09081

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1165 Madison St.,	
3. NAME OF DECEASED (Type or print) Edward LeRoy RUTTER		4. DATE OF DEATH Month July Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1892
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY STATE of MD.	
11. BIRTHPLACE (County & State, or foreign country) BALTO. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH RUTTER		14. MOTHER'S MAIDEN NAME NEWTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI		16. SOCIAL SECURITY NO. 21403 1140A	
17. INFORMANT RUTH P. RUTTER		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 7/25 , 19 67 , that (I) (we) last saw the deceased alive on 7/25 , 19 67 , and that death occurred at 7/25 M, from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman, MD		22b. DATE SIGNED 7/26/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 16 Murray Ave, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-28-67	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN	23d. LOCATION (City or Town) (County) (State) BALTO MD.
24. FUNERAL DIRECTOR John M. Sgts + Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF DEATH

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NAME	AGE	SEX	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	DATE OF BURIAL	PLACE OF BURIAL
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
09082 CERTIFICATE OF DEATH 09082										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN lb 27 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Mariea Clorinda SALUZZO					4. DATE OF DEATH Month July Day 24 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1913		9. AGE (In years lost birthday) 53 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT			11. BIRTHPLACE (County & State, or foreign country) Australia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pietro Martinis					14. MOTHER'S MAIDEN NAME Clorinda Maria Ornella					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. 324-09-8772			17. INFORMANT BRUNO SALUZZO Address Harwood, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary Edema 592X DUE TO (b) Art. C. V. Disease & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Ch. Nephritis								INTERVAL BETWEEN ONSET AND DEATH 2 months yes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Septicemia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) Wannier Klawans attended the deceased from 4/20/1967 to 7/23/1967 that (I) Wannier Klawans saw the deceased alive on 7/23/1967 and that death occurred at 3:20 PM , from causes and on the date stated above.										
22a. SIGNATURE Wannier Klawans					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) M.F. Klawans					22d. ADDRESS 31 Southgate Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 7/27/67		23c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows			23d. LOCATION (City or Town) (County) (State) Owensville, Md		
24. FUNERAL DIRECTOR TA Hardesty					ADDRESS Galesville, Md		25a. REC'D BY REGISTRAR DATE AUG 7 1967		25b. REGISTRAR'S SIGNATURE J. Charles J. J.	

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GENERAL OF DEATH

John Arnold

Raymond

John Arnold

Raymond

Raymond

Raymond

John Arnold (General Hospital)

John Arnold

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John Arnold

John Arnold

John Arnold

John Arnold

Dec. 4, 1911

Female

Raymond

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09083

09083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale		c. LENGTH OF STAY IN 1b 7 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES A. SANFORD				4. DATE OF DEATH Month Day Year July 17, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/09	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Montross Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L Sanford				14. MOTHER'S MAIDEN NAME Susie Ann Foxwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 528057358		17. INFORMANT Elmud Sanford Deale Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				22. DATE SIGNED 7/18/67			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				23. LOCATION (City or Town) (County) (State) Washington DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-21-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill, Georgetown, Washington		23d. LOCATION (City or Town) (County) (State) DC			
24. FUNERAL DIRECTOR Bernard Hurdnuty, Salisbury Md				25a. REC'D BY REGISTRAR JUL 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09084

09083

1. PLACE OF DEATH e. COUNTY <i>A-A-Co</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A-A-Co</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>		c. LENGTH OF STAY in 1b <i>1 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>111 Severn River Road</i>		d. STREET ADDRESS <i>111 Severn River Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First <i>Robert</i> Middle <i>H</i> Last <i>SAPP.</i>		4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>7-5-39</i>		9. AGE (In years last birthday) yrs. <i>27</i>		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Westinghouse</i>		11. BIRTHPLACE (State or foreign country) <i>Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Harold B. Sapp</i>		14. MOTHER'S MAIDEN NAME <i>Grove Mumford</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Harold B. Sapp</i>		17. INFORMANT <i>Theresa N.Y.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shot wound anterior Chest</i> DUE TO <i>Wave</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>977X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of Injury in Part I or Part II of item 18.) <i>Self inflicted knife wound Chest</i>		20c. TIME OF INJURY Hour a.m. <i>7/4</i> p.m. <i>1967</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>AACO MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7-4-67</i>		Address (Street, city, town, or county) <i>Severna Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-10-67</i>		22c. NAME OF CEMETERY OR CREMATORY <i>East Lawn Cem.</i>	
22d. LOCATION (City, town, or county) <i>Severna Park, Md.</i>		22e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		22f. REC'D BY REGISTRAR DATE <i>JUL 10 1967</i>	

8080

100-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
09085		CERTIFICATE OF DEATH	
09085		09085	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 49 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Baltimore Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 513 Annabel Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna T. Schuman		4. DATE OF DEATH Month July Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-03
9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months 9 Days 12 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? Baltimore Maryland	
13. FATHER'S NAME Joseph Benik		14. MOTHER'S MAIDEN NAME Brigitta Waitkas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. W. Raymond Schuman	
17. INFORMANT Mr. W. Raymond Schuman		Address 513 Annabel Ave. 21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Generalized Metastasis DUE TO (c) Carcinoma of uterus, 6 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 67 , to 7/5 , 19 67 , that (I) (we) last saw the deceased alive on 7/5 , 19 67 , and that death occurred at 12:30 AM , from causes and on the date stated above			
22a. SIGNATURE McCurdy		22b. DATE SIGNED 7/5/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn A. A. Co. Md.	
24. FUNERAL DIRECTOR McCurdy Funeral Home		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones		25c. ADDRESS 237 Patapsco Ave. 21225	

2002

STATE OF DEUTSCHLAND

1. Name of the person

2. Date of birth

3. Place of birth

4. Date of death

5. Name of the person

6. Date of birth

7. Place of birth

8. Name of the person

9. Date of birth

10. Place of birth

11. Name of the person

12. Date of birth

13. Place of birth

14. Name of the person

15. Date of birth

16. Place of birth

17. Name of the person

18. Date of birth

19. Place of birth

20. Name of the person

21. Date of birth

22. Place of birth

23. Name of the person

24. Date of birth

25. Place of birth

26. Name of the person

27. Date of birth

28. Place of birth

29. Name of the person

30. Date of birth

31. Place of birth

32. Name of the person

33. Date of birth

34. Place of birth

09086

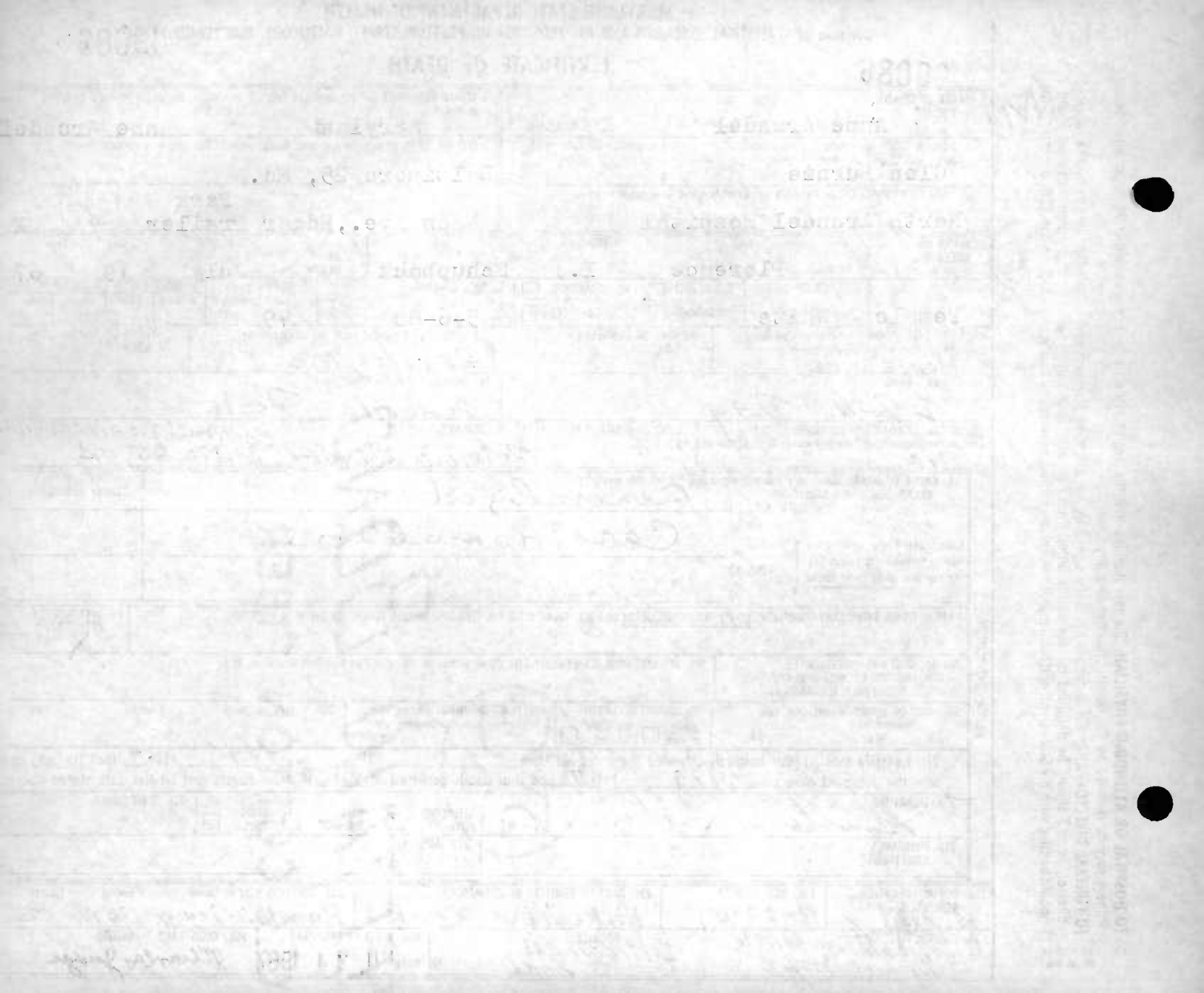
CERTIFICATE OF DEATH

09086

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnee		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Nann Ave., Edmar Trailer		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence I. Schupbak				4. DATE OF DEATH Month July Day 19 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-88	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Glenview, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME IVAN DAY				14. MOTHER'S MAIDEN NAME Isabelle Poole			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. ?		17. INFORMANT Patricia WARDEN Edmar Trailer Park Balto 25, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1992 Generalized Carcinomatosis							INTERVAL BETWEEN ONSET AND DEATH
DUE TO (a) Generalized							
DUE TO (b) Carcinomatosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/19 , 19 67 , to 7/17 , 19 67 , that (I) (we) last saw the deceased alive on 7/19 , 19 67 , and that death occurred at 8:05 PM , from causes and on the date stated above.							
22a. SIGNATURE Guillermo A. Jimenez				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-22-67		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW PARK		23d. LOCATION (City or Town) (County) (State) Randallstown Balto Md.	
24. FUNERAL DIRECTOR Ellicott City				25a. REC'D BY REGISTRAR DATE JUL 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Item 20 Film 391 8-4-67 MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2c & d Film #G391 8/3/67 ph											
09087 CERTIFICATE OF DEATH 09087											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u> Riva					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>						d. STREET ADDRESS <u>Bay Manor Nursing Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Elizabeth C. Sharkey</u> First Middle Last						4. DATE OF DEATH <u>July 22 1967</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9 1882</u>		9. AGE (In years last birthday) yrs. <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N.Y.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael Chadwick</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Murray</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wm C. Sharkey</u> Address <u>Annapolis, Minn.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> <u>INANITION</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>FRACTURE OF HIP (LEFT, 10 JULY 67)</u> DUE TO (c) _____										<u>2 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<u>ARTERIOSCLEROSIS, GENERAL & CEREBRAL WITH SENILITY</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Debilitated, patient unaided restraints, slipped when getting from bed and fell</u>							
20c. TIME OF INJURY Month, Day, Year <u>1.15 p.m. Jul 10 1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing home</u>		20f. (City or town) (County) (State) <u>AA</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10 July, 1967</u> to <u>22 July, 1967</u> , that (I) (we) last saw the deceased alive on <u>22 July 1967</u> , and that death occurred at <u>10:20 p.m.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>Charles W. Kinzer</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>24 JULY 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. KINZER, M.D.</u>						22d. ADDRESS <u>16 MURRAY AVE., ANNAPOLIS, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>			23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>				
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

18002

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09088

CERTIFICATE OF DEATH

09088

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY 204	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownville		c. LENGTH OF STAY IN lb 6/19/65	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownville State Hospital	
d. STREET ADDRESS 968 N. Charles Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSIE First Middle Last SHAWERS		4. DATE OF DEATH Month 7 Day 29 Year 1967	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/97
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 11 Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME More Jones		14. MOTHER'S MARRIED NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio vascular accident DUE TO (b) hypertensive cardio vascular disease DUE TO (c) some idiopathic			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 6/19/65 , 19__ to 7/29/67 , 19__, that (X) (we) last saw the deceased alive on 7/29/67 , 19__, and that death occurred at 8:35 AM , from causes and on the date stated above.			
22a. SIGNATURE L. BENEDICT M.D.		22b. DATE SIGNED 7/29/67	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		22d. ADDRESS Crownville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-1-67	23c. NAME OF CEMETERY OR CREMATORY Balto Nat Cem	23d. LOCATION (City or Town) (County) (State) Balto Md Md
24. FUNERAL DIRECTOR Eloy Wilson, 1001 Cranberry Ln		25a. REC'D BY REGISTRAR DATE AUG 1 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF COMMERCE

33320

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:
"The following information was obtained from the records of the Bureau of the Census..."
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09089

CERTIFICATE OF DEATH

09089

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-1, Box-281Z	
3. NAME OF DECEASED (Type or print) First Maeblle Middle Colingwood Last SHILES		4. DATE OF DEATH Month July Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1900
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William J. Collingwood		14. MOTHER'S MAIDEN NAME Jennie Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-34-5762	
17. INFORMANT John W. Shiles		Address Edgewater, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral High Pressure 1621 DUE TO (b) myeloid metastases DUE TO (c) 3 months		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 , to July 19, 1967 , that (I) (see) saw the deceased alive on July 19, 1967 , and that death occurred at 8:05 AM , from causes and on the date stated above.		22a. SIGNATURE Elmer G. Linhardt, M.D.	
22b. DATE SIGNED 7/19/67		22c. PHYSICIAN'S NAME (Type) Elmer G. Linhardt, M.D.	
22d. ADDRESS 3 Chesapeake Ave., Annapolis, Md.		22e. REC'D BY REGISTRAR JUL 21 1967	
22f. REGISTRAR'S SIGNATURE J. Charles Judge		23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	
23b. DATE THEREOF 7/21/67		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	
23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.		24. FUNERAL DIRECTOR T.A. Hardisty & Son, Annapolis Md	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09030

09030

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 5 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-1, Box-153A	
3. NAME OF DECEASED (Type or print) Conen Zachary First Middle Last SMITH		4. DATE OF DEATH Month July Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1967
9. AGE (In years lost birthday) yrs. 5		10. IF UNDER 1 YEAR Months Days Hours Min. 5	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harold Selvester Smith		14. MOTHER'S MAIDEN NAME Florida M. Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT David S. Smith Glen Burnie		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from July 19, 1967 , to July 19, 1967 , that (I) yes last saw the deceased alive on July 19, 1967 , and that death occurred at 11:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Stuart M. Christhilf, M.D.		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 69 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-22-1967	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis Md	
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY GEO STRAUS JUL 27 1967	
25b. REC'D BY SIGNATURE			

VR A15 (4)
25M 1/67

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09091

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. Glen Hosp</u>				d. STREET ADDRESS <u>1220 Cathedral Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Turner, Wilson, Smith</u>				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-18</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Road</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Smith</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>236-14-1385</u>		17. INFORMANT Address <u>Helen J. Smith</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Malignancy</u> DUE TO <u>Hypernephroma</u> DUE TO <u>R.C.V.D. & Coronary</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>1967</u> , that (I) (we) last saw the deceased alive on <u>7-8-67</u> , and that death occurred at <u>12:30</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Hahn</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. HAHN</u>				22d. ADDRESS <u>P.O. Box 73 Severna Park Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Adenton Md.</u>	
24. FUNERAL DIRECTOR <u>Robert Hahn</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>July 12 1967</u>							

OFFICE OF THE ATTORNEY GENERAL

10000

MEMORANDUM FOR THE ATTORNEY GENERAL

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G391 7/31/67

CERTIFICATE OF DEATH

09092

09092

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Davidsonville</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hosp.</u>				d. STREET ADDRESS <u>Covington Farm</u>			
3. NAME OF DECEASED (Type or print) <u>Lester Joseph SNODGRASS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, '14</u>	9. AGE (In years lost birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Die worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plastics</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rose Hill, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Snodgrass</u>				14. MOTHER'S MAIDEN NAME <u>RETTIE SNODGRASS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-14-0159</u>		17. INFORMANT <u>Son, James V. Snodgrass</u> Address <u>91 West St. Annapolis, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO 1621 (b) <u>Carcinoma (oat cell type) of lung</u> DUE TO 1621 (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 13</u> , 19 <u>67</u> , to <u>July 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>67</u> , and that death occurred at <u>8:20 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Kinzer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 23, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>				22d. ADDRESS <u>16 Murray Av., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HAMILTON CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>LEE COUNTY VA</u>	
24. FUNERAL DIRECTOR <u>BEALL FUNERAL HOME</u>				ADDRESS <u>1212 WEST ST.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 26 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles W. Kinzer</u>			

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH

NAME: [illegible] ADDRESS: [illegible]

DATE: [illegible] TIME: [illegible]

LOCATION: [illegible]

REMARKS: [illegible]

TEST RESULTS: [illegible]

LABORATORY: [illegible]

DATE OF TEST: [illegible]

TESTER: [illegible]

REMARKS: [illegible]

DATE OF REPORT: [illegible]

REPORTER: [illegible]

REMARKS: [illegible]

DATE OF TEST: [illegible]

TESTER: [illegible]

REMARKS: [illegible]

DATE OF REPORT: [illegible]

REPORTER: [illegible]

REMARKS: [illegible]

09093

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 97 West Street	
3. NAME OF DECEASED (Type or print) Bessie		4. DATE OF DEATH Month July Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1898
9. AGE (In years last birthday) yrs. 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? XXXXXX	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-46-0156T	
17. INFORMANT Mrs. Jack Lucas		8709 McHair Drive Alexandria, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) Massive Pulmonary Emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ac. Pulmonary edema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 days 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) old myocardial infarction. Ch. nephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 67 , to 7/16/67 , that (I) (we) last saw the deceased alive on 7/16/1967 , and that death occurred at 5:50 P.M. M, from causes on the date stated above.			
22a. SIGNATURE Minnie Klawans		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) M. F. KLAUANS, M.D.		22d. ADDRESS 31 SOUTH GATE AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel	23d. LOCATION (City or Town) (County) (State) Annapolis Anne Aru. Md.
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2025

DEPARTMENT OF HEALTH

WISCONSIN STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF PUBLIC HEALTH

DIVISION OF VETERINARY MEDICINE

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

July

2025

2025

White

Female

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

DIVISION OF VETERINARY MEDICINE

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

2025

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

2025

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

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DIVISION OF VETERINARY MEDICINE

WISCONSIN STATE DEPARTMENT OF HEALTH

DIVISION OF VETERINARY MEDICINE

July 2025

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6
1
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND09094
CERTIFICATE OF DEATH

09094

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 25 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 206 Haile Avenue				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 206 Haile Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jake Emmanuel Sowers		4. DATE OF DEATH Month July Day 5 Year 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1914	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Seaview Const. Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia			
13. FATHER'S NAME Jake E. Sowers		14. MOTHER'S MAIDEN NAME Rose A. Tutwiler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 218-07-8587		17. INFORMANT Mrs. Margaret B. Sowers Address 206 Haile Ave. 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Pericarditis 150x DUE TO Pa of esophagus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 1 month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1:58 to 7:55, 1967 that (I) (we) last saw the deceased alive on 7:55 1967 and that death occurred at 7:55 PM, from the causes and on the date stated above.							
22a. SIGNATURE H. G. Summers M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) H. G. Summers		22d. ADDRESS 11010 Patapsco Ave. Baltimore					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Meadowridge			
23d. LOCATION (City, town or county) Elkridge		(State) Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons		ADDRESS North Pa. Ave. 17-MB		25a. REC'D BY REGISTRAR JUL 7 1967			
25b. REGISTRAR'S SIGNATURE James J. Jones							

1930

STATE OF TEXAS

1930

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

WITNESSES

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WITNESSES

FOR STATE
HEALTH DEPT.

09095

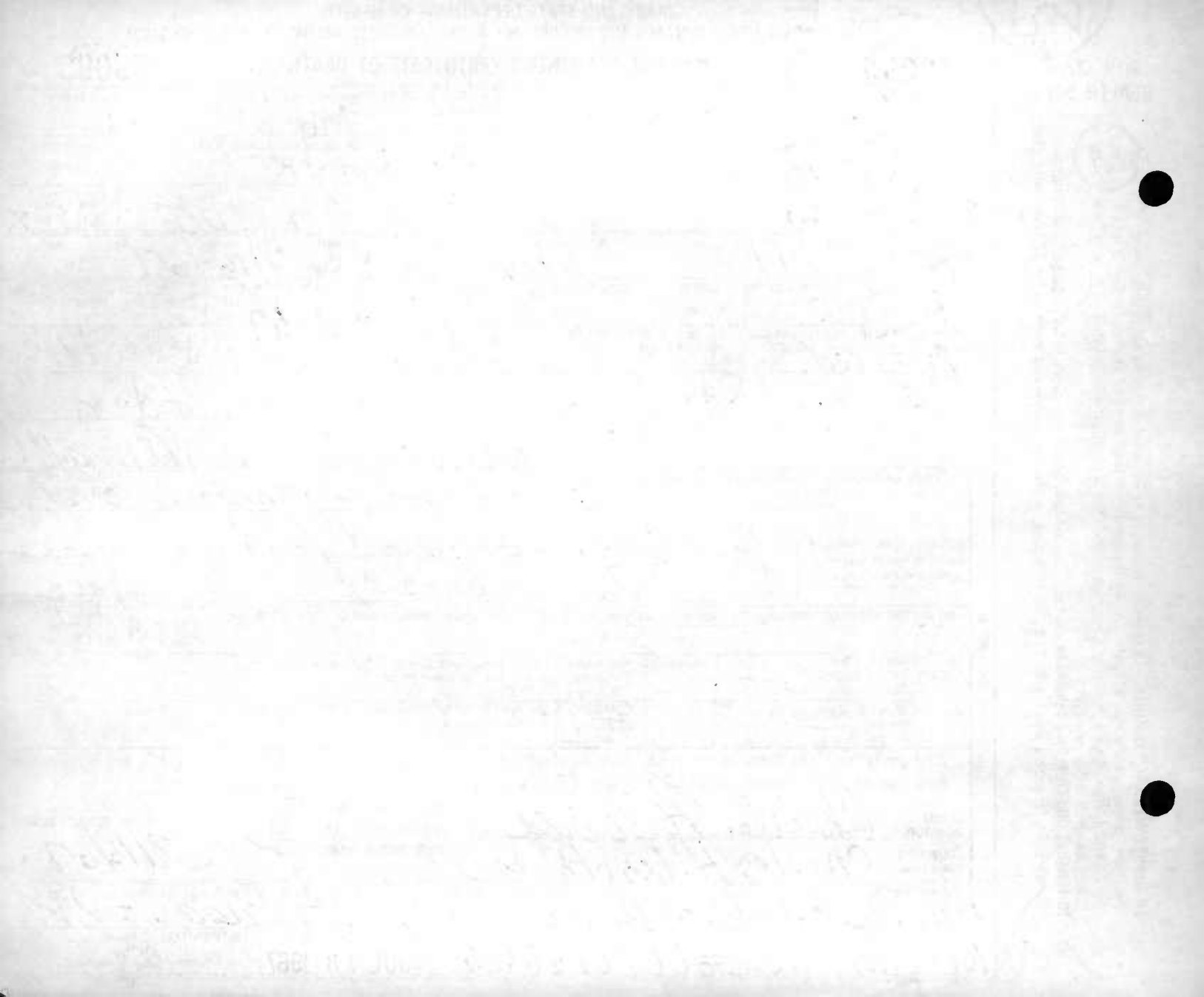
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09095

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>Rt 2 Box 105</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 2 Box 105</u>		d. STREET ADDRESS <u>Rt 2 Box 105</u>	
3. NAME OF DECEASED (Type or print) <u>Clifton</u> First <u>Stevens</u> Middle <u>Lost</u>		4. DATE OF DEATH <u>7/16/67</u> Month <u>7</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1910</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>George Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Snowden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Katherine Murray Annan</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles H. Wirth</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles H. Wirth, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>7-19-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Margarets Md</u>
24. FUNERAL DIRECTOR <u>William Reese #1</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09096

09096

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u> c. LENGTH OF STAY IN 1b <u>ANNAPOLIS MD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHERWOOD FOREST</u> d. STREET ADDRESS <u>534 LITTLE JOHN HILL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CECILE</u> Middle <u>INEZ</u> Last <u>TOWNSEND</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1872</u> 9. AGE (In years last birthday) <u>94</u> YRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>E. Boston MASS.</u>
13. FATHER'S NAME <u>JOHN COBURN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA (unk)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>Mrs. Douglas F. Miner #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular</u> DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>67</u> , to <u>7-21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-21-1967</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>F. M. Stapley</u>		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. M. STAPLEY</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODHAWK CENT.</u>	23d. LOCATION (City or Town) (County) (State) <u>EVERETT MASS</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

10000

RECORD OF DEATH

10000

(10)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Burial Place", "Burial Date", "Burial Place", "Burial Date" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 392

MARYLAND STATE DEPARTMENT OF HEALTH

9-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09098

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland		c. LENGTH OF STAY IN lb Glen Burnie, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS Dairy Farm Road	
3. NAME OF DECEASED (Type or print) JEFFERY M. TURNER		4. DATE OF DEATH Month July Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1965
9. AGE (In years last birthday) 1-11 mths.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry B. Turner		14. MOTHER'S MAIDEN NAME Ann Kadingo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Melvin Turner, Gambrills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 500 X IMMEDIATE CAUSE (a) Acute tracheobronchitis and bronchiolitis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED July 27, 1967	
ACTUAL SIGNATURE Charles S. Springatd, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 July 67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR R.V. Singleton		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

M. TURNER

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21 Film G391 8/15/67-ecg

09099

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN lb 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A-A-Cow-House		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A-A-C c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS Rt. 2 Box 628 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY KATHYLEEN UNDERWOOD		4. DATE OF DEATH Month July Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-47
9. AGE (In years lost birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Student - Student		10b. KIND OF BUSINESS OR INDUSTRY Student	
11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Underwood		14. MOTHER'S MAIDEN NAME Mary Rose Madden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT John G. Underwood - Phone		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound in the chest DUE TO (b) 919.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in chest from over 12" range with .25 Caliber pistol	
20c. TIME OF INJURY Month, Day, Year Hour 8:15 p.m. July 7 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Severna Park, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED July 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/67	
23c. NAME OF CEMETERY OR CREMATORY St. Olive Cemetery		23d. LOCATION (City or town) (County) (State) Landestown, Md.	
24. FUNERAL DIRECTOR Robert S. Baranow, Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

MEDICAL CERTIFICATION

60000

NO. 10

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CERTIFICATE OF DEATH

09100

09093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		d. STREET ADDRESS 306 DEWEY DRIVE	
3. NAME OF DECEASED (Type or print) JOHN M. VALLILLO		4. DATE OF DEATH Month JULY Day 26 Year 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 APR 1917
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer - electrical		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	
11. BIRTHPLACE (County & State, or foreign country) Elizabeth, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Vallillo		14. MOTHER'S MAIDEN NAME Asunda Figuola	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 144-015-235	
17. INFORMANT LILLIAN S. VALLILLO, 306 DEWEY DR., ANNA., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour "o.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 11:54 , from causes on and on the date stated above			
22a. SIGNATURE Arthur C. J. Brickel M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTHUR C. J. BRICKEL LT MC USNR		22d. ADDRESS USNH, ANNAPOLIS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 29, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME, WEST ST., ANNA., MD.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Juge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09100

09101

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 106 Market St.	
3. NAME OF DECEASED (Type or print) Evelyn		4. DATE OF DEATH Month July Day 24 Year 19 67	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH Sept. 4, 1914 9. AGE (In years last birthday) yrs. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland	
10b. KIND OF BUSINESS OR INDUSTRY Home		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William McCRONE		14. MOTHER'S MAIDEN NAME Elizabeth WARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic CARCINOMA OF BREAST DUE TO (b) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 170X		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 17, 1967 to July 24, 1967 that (I) (we) last saw the deceased alive on July 24, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE R. Brein		22b. OATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5:45 PM 7/25/67	
22c. PHYSICIAN'S NAME (Type) R. Brein		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-28-67	
23c. NAME OF CEMETERY OR CREMATORY St. Annes		23d. LOCATION (City or Town) (County) (State) Annapolis Md.	
24. FUNERAL DIRECTOR John M. Long		25a. REC'D BY REGISTRAR OATE JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1953:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

09101

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09102

Item #9 Film #G571-173131

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Imperial Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. Gen Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md</u> d. STREET ADDRESS <u>213 Calverton</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WADE, Robert Melvin</u>				4. DATE OF DEATH <u>7-23-67</u> 19 <u>19</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-06-08</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superior</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armed Corp</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wade</u>				14. MOTHER'S MAIDEN NAME <u>Hounee Beagle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>21701431</u>		17. INFORMANT <u>Helen L. Vermillion - Phone</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive Heart Failure</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>A.C.V.D. 2 years sept Septem</u> (c) <u>Gen art</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>1965</u> , to <u>1967</u> , 19 <u>1967</u> , that (I) (we) last saw the deceased alive on <u>7-22-67</u> 19 <u>1967</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. HAHN</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>7-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>						22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-26-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

1. Name of Deceased: John A. Jones

2. Sex: M

3. Age: 65

4. Date of Death: April 15, 1955

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Signature of Physician: Dr. J. A. Smith

8. Signature of Registrar: John A. Jones

9. Date of Registration: April 15, 1955

10. Place of Registration: Baltimore, Maryland

09103

1
FOR STATE
HEALTH DEPT.

09102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blair Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blair Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. H. North. ARNOEL - Hosp.</u>		d. STREET ADDRESS <u>401 - Snow Hill Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Lawson</u> Middle <u>Ware</u> Last <u>Ware</u>		4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-89</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ware</u>		14. MOTHER'S MAIDEN NAME <u>Josie Fortune</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>N</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Ware</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4341</u> IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>7-9-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <u>A</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, Md.</u>
24. FUNERAL DIRECTOR <u>Thos O. W. Davis</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 12 1967</u>	
ADDRESS <u>1000 Brantley Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

30:00

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09104

09103

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 506 Pasadena Rd</u>		c. LENGTH OF STAY IN 1b <u>6 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Same</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>(NMI)</u> Middle <u>Weishaar</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Weishaar</u>		14. MOTHER'S MAIDEN NAME <u>Christina Weisker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>444-1345-216-05-1840</u>	
17. INFORMANT Address <u>Paul H. Weishaar - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction, Multiple</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5m</u> <u>542</u> <u>10yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>—</u> <u>—</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> to <u>7/27</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7/25</u> 19 <u>67</u> , and that death occurred at <u>11:50 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G.W. Prichard</u>		22b. DATE SIGNED <u>7/27</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. PRICHARD M.D.</u>		22d. ADDRESS <u>Glen Burnie, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Aug. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

CERTIFICATE OF DEATH

1910

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>02-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>134 HOMELAND AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>134 HOMELAND AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM JAMES WIEDEFELD SR.</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1967</u> 9. AGE (In years last birthday) yrs. <u>77</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>BOAT BIGGER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bigger</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES M. WIEDEFELD</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW I</u> 16. SOCIAL SECURITY NO. <u>WW I</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE GEIS</u> 17. INFORMANT <u>WM J. WIEDEFELD JR. #2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>D.D.A. probably due to</u> DUE TO <u>Crown Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 1/2 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-16-67</u> , 19 <u>67</u> , to <u>7-15-67</u> that (I) (we) last saw the deceased alive on <u>5-4-67</u> , and that death occurred at <u>10:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u> 22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22b. DATE SIGNED <u>7-17-67</u> 22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-17-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. LaSalle</u> ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Jager</u> DATE <u>JUL 18 1967</u>	

STATE OF TEXAS

1950

James H. Roberts

James H. Roberts

James H. Roberts

James H. Roberts

James H. Roberts

James H. Roberts

James H. Roberts

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James H. Roberts

09106

CERTIFICATE OF DEATH

09105

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
c. LENGTH OF STAY IN 1b <u>21 days</u>		d. STREET ADDRESS <u>Rt. 9 Box 202</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph (Joe) Wilkes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired laborer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES WILKES</u>		14. MOTHER'S MAIDEN NAME <u>JANE WILKES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-03-7401A</u>	
17. INFORMANT <u>Mrs. Mary Wilkes</u>		Address <u>Pasadena, Md. Route 9 Box 202</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Systecemia</u> DUE TO (b) <u>Adenocarcinoma prostate</u> DUE TO (c) <u>Bivcho pneumonia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>A.A. CO., Maryland</u>	
24. FUNERAL DIRECTOR <u>MORTON & DYETT F.H.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 7 1967</u>	
ADDRESS <u>1701 Laurens St.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

505

09107

CERTIFICATE OF DEATH

09106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c. LENGTH OF STAY IN 1b Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Arnold			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Box 394		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hampton Mitchell WILLEN			4. DATE OF DEATH Month JULY Day 7 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 20, 1897		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Staff Accountant Ret.		10b. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dendridge J. Willen				14. MOTHER'S MAIDEN NAME Etta Emma Rock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-0808 A		17. INFORMANT Mr. Robert H. Willen Address 109 2nd Ave. Brooklyn Park 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation, recurrent DUE TO (b) Anterolateral Myocardial infarct DUE TO (c) old inferior myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) old inferior myocardial infarct							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-10-1967 , to 7-7-1967 , that (I) (we) last saw the deceased alive on 7-7-1967 , and that death occurred at M , from causes and on the date stated above							
22a. SIGNATURE Frank M. Shipley				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-8-67	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, MD.				22d. ADDRESS 121 Cathedral St. Annapolis			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Md. Balto. Co.	
24. FUNERAL DIRECTOR McCully Funeral Home				25a. REC'D BY REGISTRAR 237 Patapsco Ave. Baltimore, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

GENERAL OF DEATH

0186

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>0211</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doa Chi General Hosp.</u>		d. STREET ADDRESS <u>Crownville</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Wilson</u>		4. DATE OF DEATH Month <u>7</u> - Day <u>11</u> - Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1888</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Diggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Carr - Seaboard Park, Md</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DATE SIGNED <u>7-11-67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1967</u> to <u>7/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-11</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.		22. SIGNATURE <u>Faye W. Allen</u>	
23. PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		24. ADDRESS <u>62 Cathedral St Annapolis</u>	
25. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		26. DATE THEREOF <u>7/15/67</u>	
27. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		28. LOCATION (City or Town) (County) (State) <u>Staterbury W.A. Md.</u>	
29. FUNERAL DIRECTOR <u>William Reese, II & Anna, Md.</u>		30. REC'D BY REGISTRAR <u>JUL 12 1967</u>	
31. REGISTRAR'S SIGNATURE <u>John Judge</u>		32. DATE <u>JUL 12 1967</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tagman papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

09108

09109

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Glen Burnie P.O.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Glen Burnie P.O.</u>			
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>				d. STREET ADDRESS <u>Rte. 1, Box 271-A, Solley Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rte. 1, Box 271-A, Solley Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First</u> <u>THERESA</u> <u>(Walinski)</u> <u>WOLINSKI</u> <u>Last</u>				4. DATE OF DEATH <u>July</u> <u>28,</u> <u>19</u> <u>67.</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 4, 1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Anuszewski</u>				14. MOTHER'S MAIDEN NAME <u>Maryanna Grozinski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Andrew Wolinski, Rte. 1, Box 271-A, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Severe Arteriosclerotic Cardiovascular Disease</u> (c) <u>Diffuse Encephalopathy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diffuse Encephalopathy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1966</u> to <u>July 7, 1967</u>, that (I) (we) last saw the deceased alive on <u>7/19</u> <u>1967</u>, and that death occurred at <u>2:45pm</u> from the causes and on the date stated above.							
22e. SIGNATURE <u>Mario J. Reda</u>				22b. DATE SIGNED <u>7/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARIO J. REDA M.D.</u>				22d. ADDRESS <u>4016 RITCHIE HWY BALTO. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City, town, county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>				25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

30120

1967-1-8 JUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09103

CERTIFICATE OF DEATH

10531

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>24</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Crownsville, Maryland 21032</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Wormley</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1878</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records, Crownsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>151X</u> IMMEDIATE CAUSE (a) <u>Adeno Carcinoma of stomach with extensive mel-astasis to liver and lymph nodes.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9921</u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old pulmonary T.B.; Chronic Brain Syndrome</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/4</u> , 19 <u>43</u> , to <u>7/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>67</u> , and that death occurred at <u>3:38</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Charles H. Judge</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Mapp, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>V. of Md. Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. Reese Mortuary 108 W. Washington St. Howard</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF OHIO

WILLIAM H. HARRIS

Attorney at Law

Notary Public for the State of Ohio

My Commission Expires on 10-1-83

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in witness

Testimony

Witnessed and signed on this 10th day of May, 1982

Notary Public for the State of Ohio

WILLIAM H. HARRIS

1982

10-1-83

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Witnessed and signed on this 10th day of May, 1982

Notary Public for the State of Ohio

WILLIAM H. HARRIS

1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

091110

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

091110

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN lb <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> <u>021</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>54 North Arundel Hospital</u>				d. STREET ADDRESS <u>440 Shipley Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William S. Wooten</u>				4. DATE OF DEATH Month Day Year <u>7 9 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-93</u>		9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Edward Wooten</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lusby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-2240</u>		17. INFORMANT <u>Chart by Mrs Iona Restivo - Linthicum Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronal Thrombosis</u> DUE TO <u>Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Lower Lobe Pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7-4-</u> , 19 <u>67</u> , to <u>7-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-8-</u> 19 <u>67</u> , and that death occurred at <u>6:50</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Adam M. Merlino</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. T. O'HERLIHY</u>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Solomon's Methodist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Solomon's Calvert, Md.</u>	
24. FUNERAL DIRECTOR <u>A.A. Harkness & Son, Port Republic, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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OFFICE OF THE

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Central Division

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H. T. O'Hara
11-11-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09111

CERTIFICATE OF DEATH

10532

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.P.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Zang</u> Middle Last				4. DATE OF DEATH <u>July 29</u> Month Day Year 19 <u>67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-8-92</u>	
				9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>A.A. Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Joseph Zang</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Matilda Siegert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-28-3278</u>		17. INFORMANT Address <u>Eldridge Zang Davidsonville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 20, 1967</u> , to <u>July 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 21, 1967</u> , and that death occurred at <u>2 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Willard F. Smith</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u>				22d. ADDRESS <u>Shady Side, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quaker</u>		23d. LOCATION (City or Town) (County) (State) <u>Galesville - A.A. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Bernard O. Hardesty</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of birth
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Date of registration
12. Name of registrar
13. Name of informant
14. Name of informant's address
15. Name of informant's occupation
16. Name of informant's relationship to deceased
17. Name of informant's signature
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